

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)								
a. COUNTY <b>Carroll</b>				a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>				c. LENGTH OF STAY IN 1b <b>6 days</b>								
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Carroll County General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <b>MARK ALLEN ANTHONY</b>				First	Middle	Last	4. DATE OF DEATH <b>Jan. 3 1966</b>	Month	Day	Year		
5. SEX <b>Male</b>				6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 28 1965</b>	9. AGE (In years last birthday) yrs. <b>6</b>	IF UNDER 1 YEAR Months <b>6</b>	IF UNDER 24 HRS. Days <b>6</b>	Hours <b>06-1</b>	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Carroll Co. Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Donald F. Anthony Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Barbara Ann Long</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO.				17. INFORMANT <b>Mr. Donald Anthony Sr. Same as # 2</b>				Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity, bronch pneumonia</b>												
7511 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Meningocele</b> (c) <b>Cleft Palate</b>												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/28 1965</b> , to <b>1/3 1966</b> , that (I) (we) last saw the deceased alive on <b>1/2/66 19</b> , and that death occurred at <b>645A</b> from the causes and on the date stated above.												
22a. SIGNATURE <b>M.E. Robertson</b>				22b. DATE SIGNED <b>1/3/66</b>								
22c. PHYSICIAN'S NAME (Type) <b>M.E. Robertson</b>				M.D. ATTENDING MED. DIRECTOR STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>New Windsor, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Jan. 4 1966</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Linganore Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Unionville, Md.</b>				
24. FUNERAL DIRECTOR <b>C.M. Waltz Box 241 Sykesville, Md.</b>				25a. REC'D BY REGISTRAR <b>JAN 5 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>								

28200

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00533

## CERTIFICATE OF DEATH

00523

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Mt. Airy</b>		c. LENGTH OF STAY IN lb <b>18 Months</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>R.F.D. # 2</b>		d. STREET ADDRESS <b>R.F.D. # 2</b>	
3. NAME OF DECEASED (Type or print) <b>Roland</b>		First <b>E.</b>	Middle <b>Babylon</b>
4. DATE OF DEATH <b>Jan. 5 1966</b>		Last <b>Jan. 5 1966</b>	Month Day Year
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH <b>Oct. 30 1904</b>		9. AGE (In years last birthday) <b>61 yrs.</b>	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Carroll Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Babylon</b>		14. MOTHER'S MAIDEN NAME <b>Florence L. Phillips</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or grade of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-05-7976</b>	
17. INFORMANT <b>Mrs Mary C. Babylon Same as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac fibrillation</b>		<b>1964</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4331</b>		DUE TO (b) <b>Cardiac failure with massive cerebral embolism</b> 1-5-66	
		DUE TO (c) <b>Embolism to both femoral arteries</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OP CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from....., 19.64 to...Jan. 5....., 19.66, that (I) (we) last saw the deceased alive on...Jan. 5....., 19.66....., and that death occurred at 11:45 from the causes and on the date stated above.		22b. DATE SIGNED <b>Jan. 7, 1966</b>	
22e. SIGNATURE <b>Howard E. Hall</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <b>Sykesville, Maryland</b>
22c. PHYSICIAN'S NAME (Type) <b>Howard E. Hall, M.D.</b>		23d. LOCATION (City, town or county) (State) <b>Carroll Co. Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 8 1966</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Bethesda Cemetery</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>C.M. Waltz Box 241 Sykesville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 10 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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no fixed

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00534

CERTIFICATE OF DEATH

00524

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF ILLNESS IN 1b <b>1 yr./9 mos/</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>James</b>	Middle <b>W.</b>	Last <b>BANKS</b>
4. DATE OF DEATH <b>January 31, 1966</b>	Month <b>January</b>	Day <b>31</b>	Year <b>1966</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-12-1895</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>70 yrs.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Unkn.</b>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Burrell Banks - dec.</b>	14. MOTHER'S MAIDEN NAME <b>Mary Banks - dec.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Unkn.</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Springfield State Hospital Records</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 4201 DUE TO Conditions, If any, which gave rise to Immediate (b) <b>Arteriosclerotic cardiovascular disease</b> Years cause (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pulmonary tuberculosis, moderately advanced, inactive</b> 0022 <b>Acute brain syndrome associated with alcohol intoxication.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3-3-64</b> , 19, to <b>1-31-66</b> , 19, that (I) (we) last saw the deceased alive on <b>1-31-66</b> , 19, and that death occurred at <b>10</b> <b>M</b> on the causes and on the date stated above.	22b. DATE SIGNED <b>1/31/66</b>		
22a. SIGNATURE <b>Frances Reid Nakors,</b>	M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Frances Reid Nakors, M.D.</b>	22d. ADDRESS <b>Springfield State Hospital</b>	Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>2-2-66</b>	23b. DATE THEREOF <b>Feb. 2-1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Ed. and Med. School</b>	23d. LOCATION (City, town or county) (State) <b>Feb. 2-1966</b>
24. FUNERAL DIRECTOR <b>Newell</b>	ADDRESS <b>Petersville, Md.</b>	25a. REC'D BY REGISTRAR <b>FEB 4 1956</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

15200

15200

CECILIA GOMBERG

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

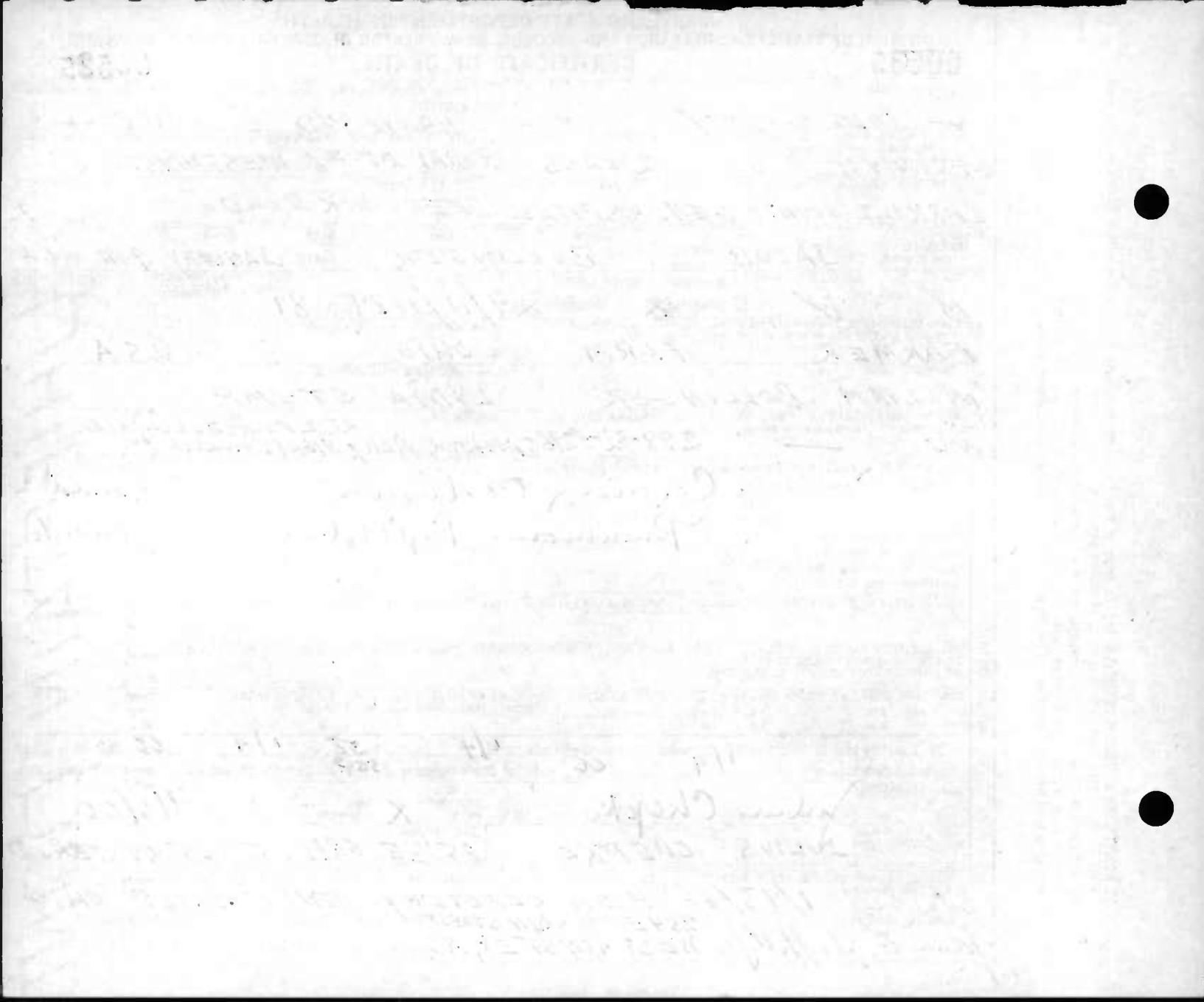
00535

CERTIFICATE OF DEATH

00525

1. PLACE OF DEATH a. COUNTY <b>CARROLL COUNTY</b> MARYLAND	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER, MD.</b>	c. LENGTH OF STAY IN 1b <b>2 YEARS</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>CARROLL COUNTY GEN. HOSPITAL</b>	d. STREET ADDRESS <b>DEER PARK ROAD</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>JACOB</b>	First Middle <b>BOLLINGER</b>	4. DATE OF DEATH Month <b>JANUARY 9TH 1966</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/11/1884</b>	9. AGE (in years last birthday) <b>81 yrs.</b>	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>	11. BIRTHPLACE (County & State, or foreign country) <b>OHIO</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>WILLIAM BOLLINGER</b>	14. MOTHER'S MAIDEN NAME <b>LYDIA STUMP</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b>288-32-5296</b>	17. INFORMANT <b>RT. 2 FINKSBURG, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 490X Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonia, Right lobar</b> (c)				Address <b>DAUGHTER MARY NIGHTENGALE</b>	
				INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
				INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>RT. 2 FINKSBURG, MD.</b>	(County) <b>CARROLL</b>	(State) <b>MARYLAND</b>
21. I certify that (I) (this hospital) attended the deceased from <b>1/4</b> , 19 <b>58</b> , to <b>1/9</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>1/9</b> , 19 <b>66</b> , and that death occurred at <b>5599 M</b> , from the causes and on the date stated above.	22a. SIGNATURE <b>S. Julius Chepko</b>	22b. DATE SIGNED <b>1/9/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>S. Julius Chepko</b>	M.D. <input type="checkbox"/> ATTENDING PHYS. 22d. ADDRESS <b>85 1/2 E. GREEN ST. WESTMINSTER MD</b>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>1/13/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>FISH CEMETERY</b>	23d. LOCATION (City, town or county) <b>NEW ROCHESTER, OHIO</b>	(State)
24. FUNERAL DIRECTOR <b>James G. Saffell Jr.</b>	254 E. MAIN STREET	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	DATE <b>12 1966</b>



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00536

## CERTIFICATE OF DEATH

00528

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH e. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodbine</i>		c. LENGTH OF STAY IN 1b c. LENGTH OF STAY IN 1b <i>Golden Age Guest House</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Golden Age Guest House</i>		d. STREET ADDRESS <i>ELLICOTT CITY 13-2</i>	
3. NAME OF DECEASED (Type or print) <i>Bertha</i>		First <i>B</i>	Middle <i>ertha</i>
3. NAME OF DECEASED (Type or print) <i>Bertha</i>	4. DATE OF DEATH Last <i>B</i>	Month <i>Jan</i>	Day <i>29</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Nov. 7, 1875</i>	9. AGE (In years last birthday) <i>97 yrs.</i>	10. IF UNDER 1 YEAR Months <input type="checkbox"/>	11. IF UNDER 24 HRS. Hours <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <i>Howard Co. Md.</i>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>JOHN SMALL WOOD</i>	14. MOTHER'S MAIDEN NAME <i>REBECCA HIRSHLEY</i>	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> <i>No</i>	16. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT <i>Lewis N. Boone, ELLICOTT CITY MD</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201</i>		INTERVAL BETWEEN ONSET AND DEATH <i>None</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) } (c)		DUE TO <i>Coronary Occlusion</i>	
		DUE TO <i>Ch. Myocarditis</i>	
		DUE TO <i>Generalized Sclerosis</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a.m. p.m. <i>19</i>	Month, Day, Year <i>1966</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>ST JOHNS</i>
20f. (City or town) <i>ELLICOTT CITY</i>	(County) <i>MD</i>	(State) <i>MARYLAND</i>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
21. I certify that (I) (this hospital) attended the deceased from <i>Dec 11, 1966</i> to <i>Jan 30, 1966</i> , that (I) (we) last saw the deceased alive on <i>Jan 30, 1966</i> , and that death occurred at <i>30</i> M, from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE <i>M. N. Mastin</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <i>M. N. MASTIN</i>		STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>2-3-66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>ST JOHNS</i>	23d. LOCATION (City, town or county) (State) <i>ELLICOTT CITY MD</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>F.C. HIGGINBOTHAM, ELLICOTT CITY MD</i>	ADDRESS	25a. REC'D BY REGISTRAR <i>FEB 7 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

00537 00527

1.		PLACE OF DEATH a. COUNTY <b>CARROLL</b>	MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>CARROLL</b>			
		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b>	c. LENGTH OF STAY IN 1b <b>20 HOURS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b>		d. STREET ADDRESS <b>UNIONTOWN ROAD</b>			
60		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>CARRILL Co GENERAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3.		NAME OF DECEASED (Type or print) <b>CARRIE ZEMORA BUFFINGTON</b>	First <b>CARRIE</b>	Middle <b>ZEMORA</b>	Last <b>BUFFINGTON</b>	4. DATE OF DEATH <b>1 6 1966</b>	Month <b>1</b>	Day <b>6</b>	Year <b>1966</b>	
5.		SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT 25- 1905</b>	9. AGE (In years last birthday) <b>60</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Hours <b>0</b>	IF UNDER 24 HRS Minutes <b>0</b>	
10a.		USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE KEEPER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13.		FATHER'S NAME <b>CHARLES C CRABBS</b>	14. MOTHER'S MAIDEN NAME <b>AMELIA COHEN HAVER</b>		Address <b>R5 MD</b>					
15.		WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT <b>EMORY BUFFINGTON</b>	INTERVAL BETWEEN ONSET AND DEATH <b>24 HOURS</b>					
18.		CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR ACCIDENT</b>								
		4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR</b> (c) <b>DISEASE</b>								
		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>RHEUMATIC HEART DISEASE</b>								
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c.		TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>WESTMINSTER</b>	(County) <b>MD</b>	(State)			
21.		I certify that (I) (this hospital) attended the deceased from <b>1/5</b> , 19 <b>66</b> , to <b>1/6</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>1/6</b> , 19 <b>66</b> , and that death occurred at <b>405</b> M, from the causes and on the date stated above.								
22a.		SIGNATURE <b>Vincent J Fiocco Jr</b>	22b. DATE SIGNED <b>1/6/66</b>							
22c.		PHYSICIAN'S NAME (Type) <b>DR VINCENT J FIOCO</b>	M.O. PHYS. <input type="checkbox"/>	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <b>WESTMINSTER MD</b>			
23a.		BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>1/9/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>LUTHERAN</b>	23d. LOCATION (City, town or county) <b>UNIONTOWN MD</b>					
24.		FUNERAL DIRECTOR <b>DD Hartzler &amp; Sons New Windsor, Md</b>	ADDRESS <b>10 1966</b>	25a. REC'D BY REGISTRAR <b>Charles Judge</b>	25b. REGISTRAR'S SIGNATURE					
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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

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00538

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

111528

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Carroll County Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 59 Admiral Blvd.			
3. NAME OF DECEASED (Type or print)	First Lillian	Middle B.	Last Carr	4. DATE OF DEATH / 14 1966	Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 28, 1905	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania	
13. FATHER'S NAME George R. Sheesley		14. MOTHER'S MAIDEN NAME Rose M. Mc Gaughey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address Grant H. Sheesley 59 Admiral Blvd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BLEEDING ESOPHAGEAL VARICES 580X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) POST NECROTIC CIRRHOSIS DUE TO (c) YEARS					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROTIC HEART DISEASE					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 1/12, 1966 to 1/14, 1966, to saw the deceased alive on 1/14, 1966, and that death occurred at 2 PM, from the causes and on the date stated above.					
22a. SIGNATURE Vincent J. Froccia Jr.					
22b. DATE SIGNED 1/14/66					
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/17/66	23c. NAME OF CEMETERY OR CREMATORIAL Meadow Ridge	23d. LOCATION (City, town or county) (State) Dorsey, Md.		
24. FUNERAL DIRECTOR Ullrich Funeral Home	ADDRESS Dundalk, Md.	25a. REC'D BY REGISTRAR DATE JAN 18 1966	25b. REGISTRAR'S SIGNATURE Charles Judge		

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1		00539		00529	
1. PLACE OF DEATH a. COUNTY		Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE	
b. CITY OR TDWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY	
(Rural) Sykesville		1yr 0m 3 da	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	Maryland	
Springfield State Hospital			Silver Spring 15 - 2	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
			d. STREET ADDRESS	d. IS RESIDENCE ON A FARM?	
			2103 Belvedere Boulevard	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH Month Day Year
Truman		Ross	Cissel		1 29 66
5. SEX		6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH
M		W	<input type="checkbox"/> WIDOWED	<input type="checkbox"/> DIVORCED	9-3-1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)	
Merchant - Retired		-Self employed		Maryland	
12. CITIZEN OF WHAT COUNTRY?		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Wilbur Cissel		Helen F. Cissel		C/ARA E. BROWN.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
unknown --		217-32-0979		Mrs. Dorothy C. Lehnhuh, S.S., Md. Hospital Records 2103 Belvedere Blvd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		wks. or mos.			
446X Heart failure and kidney failure.					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		years			
(b) Arteriosclerotic heart disease.					
DUE TO (c) Nephrosclerosis.		years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome associated with cerebral arterio-sclerosis with psychotic reaction		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)			
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20c. TIME OF INJURY Month, Day, Year Hour a.m. --- p.m. --- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	
(State)				(City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1-26, 1965, to 1-29, 1966, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 1-29, 1966, and that death occurred at 6:15A.M. from the causes and on the date stated above.		22b. DATE SIGNED			
22a. SIGNATURE Frances Reid Nabors,		Jan 29, 1966			
22c. PHYSICIAN'S NAME (Type) Frances Reid Nabors		M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	
22d. ADDRESS Springfield State Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-4-66	23c. NAME OF CEMETERY OR CREMATORIUM St. Marks Epis. Cemetery	23d. LOCATION (City, town or county) (State) R Fairland Maryland	
24. FUNERAL DIRECTOR John B. Shouse		ADDRESS 8434 Georgia Avenue	25a. REC'D BY REGISTRAR FEB 7 1966		25b. REGISTRAR'S SIGNATURE Charles Judge
Warren E. Bumpfrey, Ind. Silver Spring, Md.					

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00540

CERTIFICATE OF DEATH

00530

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville 15 dys.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 30-4	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS 903 Lake Dr apt 8C	
3. NAME OF DECEASED (Type or print) <b>ELI</b>		First <b>ELI</b>	Middle <b></b>
Last <b>COHEN</b>		4. DATE OF DEATH <b>JANUARY 25 1966</b>	Month Day Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-17-1894</b>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <b>71 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Joseph Cohen</b>		14. MOTHER'S MAIDEN NAME <b>Eloise (last name unk.)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>212-65-9303</b>	
		17. INFORMANT Records, Springfield State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH Days	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral bronchopneumonia, massive</b>			
491X Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO DUE TO (b) (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-10-66, 19 6:00 PM, to 1-25-66, 19 , that (I) (we) last saw the deceased alive on 1-25-66 19 , and that death occurred at M, from the causes and on the date stated above.		22b. DATE SIGNED <b>1-26-66</b>	
22a. SIGNATURE <i>Octavio A Ruiz</i>		M.O. ATTENDING PHYS. <input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22d. ADDRESS Springfield State Hospital Sykesville, Maryland
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/27/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Glenwood Cemetery</b>
24. FUNERAL DIRECTOR <b>Sol Lennar &amp; Bros Inc</b>		25a. REC'D BY REGISTRAR <b>FEB 1 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>
VR A15 (4) 20M 1/65		DATE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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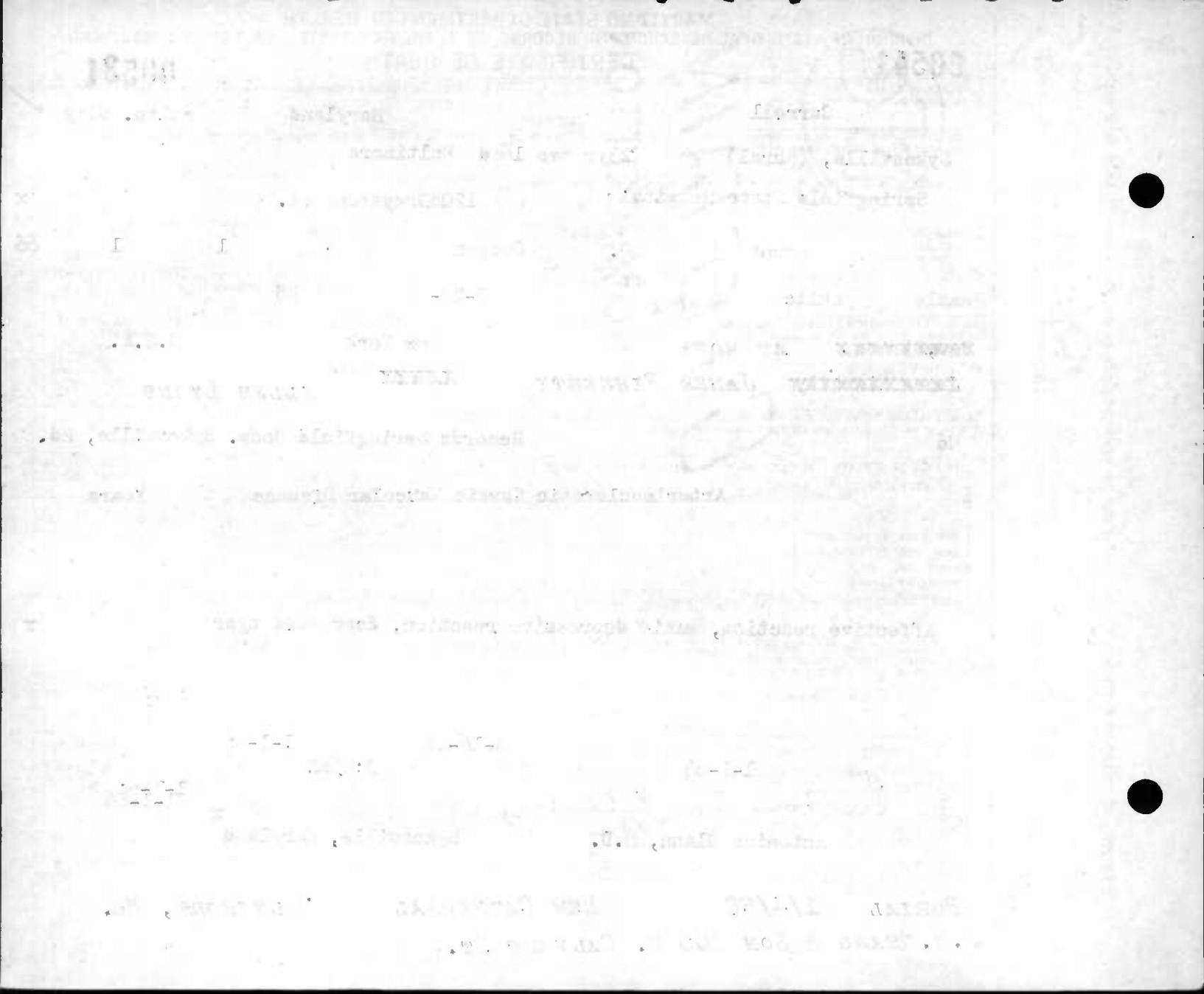
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00541

CERTIFICATE OF DEATH

00531

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. CDNTY <b>Balto. City</b>	
b. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville, (rural)</b>		c. LENGTH OF STAY IN 1b <b>23yr 6mo 16</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>		e. IS RESIOENCE ON A FARM? YES <input type="checkbox"/> ND <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Agnes</b>	Middle <b>G.</b>	Last <b>Coogan</b>
4. DATE OF DEATH <b>1 1 66</b>	Month <b>1</b>	Day <b>1</b>	Year <b>66</b>
5. SEX <b>Female</b>	6. COLOR DR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-22-77</b>
9. AGE (In years last birthday <b>88</b> yrs.)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesperson AT HOME</b>	11. KIND OF BUSINESS OR INDUSTRY <b>10b. INDUSTRY</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>James Finnerty</b>	14. MOTHER'S MADDEN NAME <b>ELLEN LYONS</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No	
16. SDICIAL SECURITYND.		17. INFORMANT <b>Records Springfield Hosp. Sykesville, Md.</b>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterioocclusive Cardio Vascular Disease</b>			
4221 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
Affective reaction, manic depressive reaction, depressed type			
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE DF INJURY(Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>6-16-62</b> , 19, to <b>1-1-66</b> , 19, that (I) (we) last saw the deceased alive on <b>1-1-66</b> , 19, and that death occurred at <b>3:45 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Antonius Glahn</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>1-1-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Antonius Glahn, M.D.</b>		22d. ADDRESS <b>Sykesville, Maryland</b>	
23a. BURIAL, CREMATION, REMDVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1/4/66</b>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>NEW CATHEDRAL</b>		23d. LOCATION (City, town or county) (State) <b>BALTIMORE MD</b>	
24. FUNERAL DIRECTOR <b>H.W. MEARS &amp; SON 805 N. CALVERT St.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 4 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



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**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

00542

**CERTIFICATE OF DEATH**

00532

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>5½ yrs.</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Howard</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brookville, Md.</b>			
3. NAME OF DECEASED (Type or print) <b>Lavinia Duchemin Currier</b>		First	Middle	Last	4. DATE OF DEATH <b>January 11 1966</b>	Month	Day	Year	13-2
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-25-1865</b>	9. AGE (In years last birthday) <b>100 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Canada</b>		12. CITIZEN OF WHAT COUNTRY? <b>Canada</b>			
13. FATHER'S NAME <b>Duchemin</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Mrs. Buelah F. Sargent Brookville, Md.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> 4200 DUE TO									
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> Weeks									
DUE TO (c) <b>Generalized Arterio-sclerosis</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>JUNE</b> , 19 <b>65</b> , to <b>1-14</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>1-14</b> , 19 <b>66</b> , and that death occurred at <b>Home</b> , from the causes and on the date stated above.									
22a. SIGNATURE <i>Suha Ozgun.</i>		22b. DATE SIGNED <b>1-14-66</b>							
22c. PHYSICIAN'S NAME (Type) <b>Suha Ozgun</b>		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-17-66</b>		23c. NAME OF CEMETERY OR OREMATORY <b>Oak Grove</b>		23d. LOCATION (City, town or county) (State) <b>Hawthorn Woods Md.</b>			
24. FUNERAL DIRECTOR <i>Miller &amp; Haight Sykesville, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR <b>IAN 18 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**00543**

**CERTIFICATE OF DEATH**

**00533**

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <span style="float: right;">MARYLAND</span>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Taneytown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Taneytown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>48 Middle Street</b>		d. STREET ADDRESS <b>48 Middle Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Raymond</b>	Middle <b>Fleagle</b>	Last <b>Davidson</b>
4. DATE OF DEATH	Month <b>January</b>	Day <b>21</b>	Year <b>1966</b>
5. SEX	6. COLOR OR RACE <b>Male</b> <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 4, 1890</b>
9. AGE (In years last birthday) <b>75 yrs.</b>	10. IF UNDER 1 YEAR <b>Months</b>	11. IF UNDER 24 HRS. <b>Days</b>	12. IF UNDER 24 HRS. <b>Hours</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Route Salesman</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Bakery</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Carroll Co., Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Charles Davidson</b>	14. MOTHER'S MAIDEN NAME <b>Sarah Fleagle</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>215-32-1265</b>	17. INFORMANT <b>Ralph Davidson</b>	Address <b>RFD Westminster, Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Heart Disease</b>			
DUE TO (c) <b>Generalized Arteriosclerosis</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>			
4 yrs			
8 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Obesity			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Hour a.m. <b>19</b>	Month, Day, Year p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1957</b> to <b>1966</b> , that (I) (we) last saw the deceased alive on <b>12/12/1963</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>E. Ambler Thompson</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>1/22/66</b>
22c. PHYSICIAN'S NAME (Type) <b>E. Ambler Thompson</b>		22d. ADDRESS <b>Taneytown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/24/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Lutheran Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Taneytown, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>C.O. Fuss &amp; Son</b>	25a. REC'D BY REGISTRAR <b>JAN 25 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY Carroll				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland				b. COUNTY Washington							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 6 mos. 1 dy				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS Route #1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First ERIE	Middle HALET	Last DE HART	4. DATE OF DEATH January 4 1966	Month January	Day 4	Year 1966							
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11-25-90	9. AGE (In years last birthday) 75 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. HOURS Min. 0							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Engineer				10b. KIND OF BUSINESS OR INDUSTRY W.M.R.R.				11. BIRTHPLACE (County & State, or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME S. Rufus Dehart				14. MOTHER'S MAIDEN NAME Lansey A. Bowers				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 705-10-6782 17. INFORMANT Records, Springfield State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease								INTERVAL BETWEEN ONSET AND DEATH years							
4221 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)				DUE TO (b) (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 7-3-65, 19, to 1-4-66, 19, that (I) (we) last saw the deceased alive on 1-4-66, 19, and that death occurred at 5:45 p.m. M, from the causes and on the date stated above.								22a. SIGNATURE Octavio A. Ruiz				22b. DATE SIGNED 1-5-66			
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M.D.				22d. ADDRESS Springfield State Hospital Sykesville, Maryland				23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1-7-66 23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery			
24. FUNERAL DIRECTOR James T. Powers Rest Haven Funeral Chapel, Inc. HAGERSTOWN, MD.				ADDRESS				25a. REC'D BY REGISTRAR JAN 6 1966				25b. REGISTRAR'S SIGNATURE Charles Judge			

ME200

ME200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00545

CERTIFICATE OF DEATH

00535

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN lb <b>9 yr. 3 mo. 2</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>dys. Bethesda</b>		d. STREET ADDRESS <b>15 - 2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>WINONA</b>	Middle <b>MARGARET</b>	Last <b>EBERHART</b>	4. DATE OF DEATH <b>January 18</b>	Month <b>19</b>	Day <b>66</b>	Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-17-03</b>	9. AGE (In years last birthday) <b>62</b> yrs.	10. KIND OF BUSINESS OR INDUSTRY <b>Unk.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Indiana</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>David C. Eberhart</b>			14. MOTHER'S MAIDEN NAME <b>Jeanette Fertich</b>			Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT <b>Unk.</b>	Records, Springfield State Hospital				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> 4201 DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <b>Coronary occlusion</b> DUE TO (c) <b>Arteriosclerotic heart disease</b> INTERVAL BETWEEN ONSET AND DEATH days days years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <b>Schizophrenic reaction, paranoid type.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>10-16-56</b>	20f. (City or town) <b>1-18-56</b>	(County) <b>19</b>	(State) <b>19</b>	21. I certify that (I) (this hospital) attended the deceased from 1-18-66 to 1-18-56, that (I) (we) last saw the deceased alive on 1-18-66, and that death occurred at 9:45 A.M. from the causes and on the date stated above.	19
22a. SIGNATURE <i>Dr. Antonius Glahn</i>	22b. DATE SIGNED <b>1-18-66</b>						
22c. PHYSICIAN'S NAME (Type) <b>Antonius Glahn, M.D.</b>	22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland 21784</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>1-24-66</b>	23b. DATE THEREOF <b>1-24-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>U.S. Med. School</b>	23d. LOCATION (City, town or county) <b>Baltimore Md.</b>	(State)			
24. FUNERAL DIRECTOR <b>Newell Funeral Home</b>	ADDRESS <b>P.O. Box 11000</b>	25a. REC'D BY REGISTRAR <b>CHARLES JUDGE</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	DATE <b>JAN 25 1966</b>			

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PA 1970

1970

Vermin

birds

1970

number of birds seen during the survey

at

and which species

indicated their distribution

vernal

nesting birds

in 1970

50

50-100

100+

number

of birds seen

during the survey

in which building or structure was seen

nesting birds in 1970

over

number of birds

seen in each object

and determine whether it may be

seen again in 1970

in which building

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00546				00536							
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 30 - 4							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED First Middle Last (Type or print) <b>Florence Elizabeth Ellis</b>				4. DATE OF DEATH Month Day Year <b>Jan. 2 1966</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-3-87</b>		9. AGE (In years last birthday) <b>78 yrs.</b>		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John J. Corbitt</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth McGeeney</b>				Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Husband's No. 212-09-4052</b>				17. INFORMANT <b>Springfield Hpsp. Records Sykesville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriovenous Cardiac Failure</b>											
4221 OUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b>											
DUE TO (c) <b>Cerebral Brain Syndrome Associated with Cerebral Arteriosclerosis with behavioral reaction</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic Brain Syndrome Associated with Cerebral Arteriosclerosis with behavioral reaction</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 6, 1965</b> , to <b>Jan. 2, 1966</b> , that (I) (we) last saw the deceased alive on <b>JAN 2 1966</b> , and that death occurred at <b>Baltimore</b> M, from the causes and on the date stated above.				22b. DATE SIGNED <b>JAN 2 1966</b>							
22a. SIGNATURE <b>Robert N. Deeb</b>				22b. DATE SIGNED <b>JAN 2 1966</b>							
22c. PHYSICIAN'S NAME (Type) <b>Robert N. Deeb</b>				22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>1-5-65</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>NEW CATHEDRAL</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore MD</b>			
24. FUNERAL DIRECTOR <b>Chas. F. Evans &amp; Son</b>				ADDRESS <b>8802 Harford Rd</b>		25a. REC'D BY REGISTRAR <b>JAN 4 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			
VR A15 (4) 20M 1/65											

Q5200

economic areas. It is  
likely environmental sites  
will be more easily affected  
and will be more difficult  
to identify.

Environmental factors  
such as soil type, water  
availability, and climate  
are important in determining  
the potential impact of  
environmental changes on  
natural resources. These  
factors can affect the  
ability of plants and animals  
to adapt to changing  
conditions. For example,  
changes in temperature  
can affect the growth and  
survival of certain species.  
Similarly, changes in  
precipitation patterns  
can affect the availability  
of water for plants and  
animals. Changes in  
soil type can also affect  
the ability of plants to  
grow and survive. For  
example, changes in soil  
texture or pH can affect  
the availability of nutrients  
to plants. Changes in  
climate can also affect  
the availability of water  
for plants and animals.  
For example, changes in  
temperature can affect  
the growth and survival  
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changes in precipitation  
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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

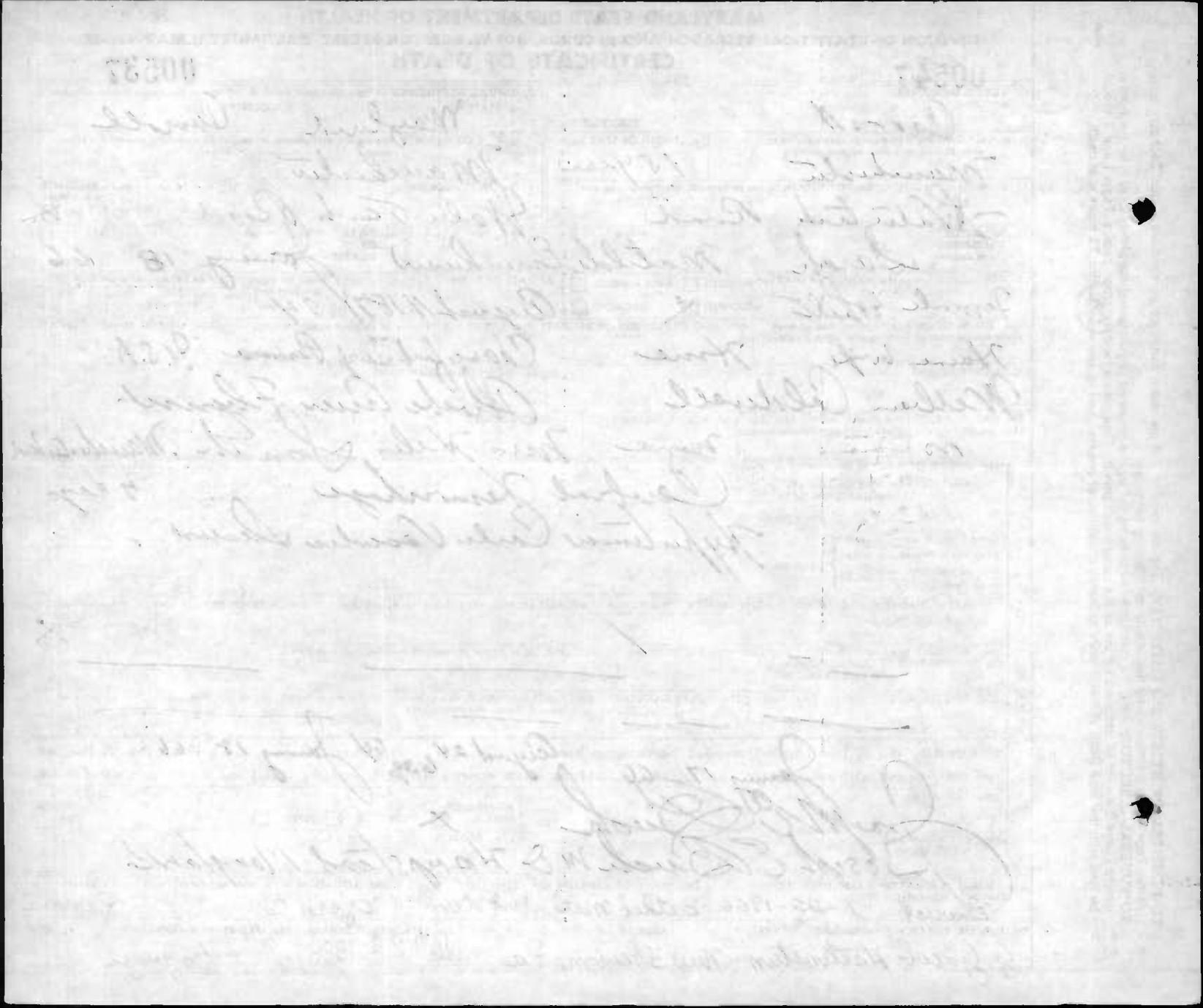
## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester		c. LENGTH OF STAY IN b. 15 years				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Waterfall Road		d. STREET ADDRESS Waterfall Road				
3. NAME OF DECEASED (Type or print)	First Sarah	Middle Matilda	Last Emendusen			
4. DATE OF DEATH	Month January	Day 18	Year 1966			
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH			
Female White	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	August 11, 1871			
9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months 94	11. IF UNDER 24 HRS. Deyrs 94				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	11b. KIND OF BUSINESS OR INDUSTRY Home	12. CITIZEN OF WHAT COUNTRY? Chancery, Juap, Penna U.S.A.				
13. FATHER'S NAME William Caldwell	14. MOTHER'S MAIDEN NAME Phoebe Curr Flynn					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No	16. SOCIAL SECURITY NO.	17. INFORMANT				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address				
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH				
443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		7 days				
(b) DUE TO						
(c) DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED?				
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1B.)				
20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
Hour e.m. p.m.	19	While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
21. I certify that (I) (this hospital) attended the deceased from August 24, 1966, to January 18, 1966, that (I) (we) last saw the deceased alive on January 17, 1966, and that death occurred at 6:38 A.M., from the causes and on the date stated above.						
22e. SIGNATURE Joseph E. Bush M.D.						
22f. PHYSICIAN'S NAME (Type) Joseph E. Bush M.D. Hampsstead Maryland						
23e. BURIAL, CREMATION, REMOVAL (Specify) Burial	23f. DATE THEREOF 1-22-1966	23g. NAME OF CEMETERY OR CREMATORIAL Bether Methodist Cemetery	23h. LOCATION (City, town or county) York Co.	(State) Pennsylvania		
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS						
E. Jacob Hartenstein New Freedom, Pa.						
25a. REC'D BY REGISTRAR DATE JAN 24 1966	25b. REGISTRAR'S SIGNATURE					
Charles Judge						

16200



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00548

CERTIFICATE OF DEATH

00538

1		Item #1 Film #6373 2/7/66		2	
1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Carroll		Maryland		4 mo,	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Sykesville				Baltimore City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Springfield State Hospital		3703 6th Street,		12	
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month
ANNA DOMINYAK ENGEL				JANUARY	Day
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	Year
female		white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	02-07-89	25
9. AGE (In years last birthday)		10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY? U.S.A. naturalized.	
76 yrs.		Hungary			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
STEVE DOMINYAK		Anna Gajdas			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	17. INFORMANT	Address	
Records of Springfield State Hospital, Sykesville					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary artery embolism, source unknown 4200 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)					
INTERVAL BETWEEN ONSET AND DEATH minutes years					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) BALTIMORE	(County) (State) MD
21. I certify that (I) (this hospital) attended the deceased from 9-22-65, 1965, to 1-2, 1966, that (I) (we) last saw the deceased alive on 1-2, 1966, and that death occurred at 11:57 AM, from the causes and on the date stated above.					
22a. SIGNATURE <i>Manuscript</i>		M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 1/24/66
22c. PHYSICIAN'S NAME (Type) <i>Manuscript</i>		22d. ADDRESS Springfield State Hospital, Sykesville,			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/28/66	23c. NAME OF CEMETERY OR CREMATORIAL GARDEN OF FAITH ADDRESS Frances Deller House 222 S. HIGH ST.	23d. LOCATION (City, town or county) BALTIMORE (State) MD	
24. FUNERAL DIRECTOR <i>Frank Deller House</i>		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 28 1966 <i>Gloucester Judge</i>			
15M 4-64					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**00549**

**CERTIFICATE OF DEATH**

**00539**

**1. PLACE OF DEATH**  
a. COUNTY

Carroll

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Woodbine

c. LENGTH OF STAY IN 1b

Life

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Woodbine

**3. NAME OF  
DECEASED  
(Type or print)**

First

Middle

Last

Charles

M.

Frederick

**5. SEX**

Male

**6. COLOR OR RACE**

White

**7. MARRIED**  **NEVER MARRIED**

WIDOWED  DIVORCED

**B. DATE OF BIRTH**

Oct. 27 1893

9. AGE (In years  
last birthday)

72

yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Plumber

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Carroll Co. Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Thomas E. Frederick

Fannie I. Mills

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

219-20-1257

Mrs Estella G. Frederick Same as #2

INTERVAL BETWEEN  
ONSET AND DEATH  
1964

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Cerebral hemorrhage

4331  
DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last. (b) Articular fibrillation, cardiac failure

1-7-66

DUE TO

(c) Arteriosclerosis generalized, diabetes

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m. 19  
p.m.

20d. INJURY OCCURRED  
While at work  Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from....., 1964, to Jan. 7, 1966, that (I) (we) last saw the deceased alive on Jan. 7, 1966, and that death occurred at 7:40 A.M. from the causes and on the date stated above.

22e. SIGNATURE

Howard E. Hall

M.D.

22b. DATE SIGNED  
Jan. 7, 1966

22c. PHYSICIAN'S  
NAME (Type)

Howard E. Hall, M.D.

ATTENDING  
PHYS.   
MED. DIRECTOR   
STAFF PHYS.

22d. ADDRESS

Sykesville, Maryland

23a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

23b. DATE THEREOF

Jan. 10 1966

23c. NAME OF CEMETERY OR CREMATORIUM

Morgan Chapel

23d. LOCATION (City, town or county)

Carroll Co. Md.

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

C.M. Waltz Box 241 Sykesville, Md.

ADDRESS

25e. REC'D BY REGISTRAR  
DATE JAN 10 1966

25f. REGISTRAR'S SIGNATURE  
Charles Judge

00001

1200

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH						00550 00540								
1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>CARROLL</b>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SYKESVILLE</b> c. LENGTH OF STAY IN 1b <b>25 years</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SYKESVILLE 06-1</b>								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS <b>MAIN ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)			First <b>DAVID</b>	Middle <b>W.</b>	Last <b>GREEN</b>	4. DATE OF DEATH <b>JAN. 17 1966</b>			Month	Day	Year			
5. SEX <b>MALE</b>			6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 19, 1880</b>	9. AGE (in years last birthday) <b>85 yrs.</b>			IF UNDER 1 YEAR <input type="checkbox"/> Months <b>8</b>	IF UNDER 24 HRS <input type="checkbox"/> Days <b>5</b>	Hours <b>0</b> Min. <b>00</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER (RETIRED)</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>AGRICULTURE</b>			11. BIRTHPLACE (County & State, or foreign country) <b>PENNA.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>THOMAS P. GREEN</b>			14. MOTHER'S MAIDEN NAME <b>MARY BOWSER</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>MR RICHARD GREEN - WOODBINE, Md.</b>			17. INFORMANT <b>Address</b>								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>1960</b> 4201 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> through (c) <b>Arteriosclerosis, generalized.</b> 1-17-66														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20d. INJURY OCCURRED			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>1960</b> , to <b>Jan. 17, 1966</b> , that (I) (we) last saw the deceased alive on <b>Jan. 17, 1966</b> , and that death occurred at <b>12 AM</b> , from the causes and on the date stated above.			22b. DATE SIGNED <b>JAN. 18, 1966</b>											
22a. SIGNATURE <b>Howard E. Hahn</b>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
22c. PHYSICIAN'S NAME (Type) <b>HOWARD E. HAHN</b>			22d. ADDRESS <b>SYKESVILLE, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>1-20-66</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>ADDISON</b>			23d. LOCATION (City, town or county) <b>ADDISON, PA.</b>			(State)		
24. FUNERAL DIRECTOR <b>Butler A. Haight</b>			ADDRESS <b>Oleyville, Md.</b>			25a. REC'D BY REGISTRAR <b>JAN 24 1966</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					
VR A15 (4) 20M 1/65														

85

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
00551				00541											
1. PLACE OF DEATH 2. COUNTY		CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)									
b. CITY OR TDWN (If outside corporate limits, write RURAL and give nearest town)		NEW WINDSOR RURAL YEARS				a. STATE		MARYLAND CARROLL							
c. LENGTH OF STAY IN 1D						b. COUNTY									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						c. CITY OR TDWN (If outside corporate limits, write RURAL and give nearest town)		NEW WINDSOR RURAL 06-1							
e. IS RESIDENCE ON A FARM?						d. STREET ADDRESS									
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH		Month	Day	Year						
EPHRIAM THOMAS HILL				HILL	JAN	25	1966								
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)		IF UNDER 1 YEAR	IF UNDER 24 HRS.							
M		COL	WIDDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	DEC 24-1877 58 yrs.	Months	Days	Hours	Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?						
LABORER			HOTEL LABORER			MARYLAND			USA						
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME													
SAMUEL HILL		MARGARET JOBES													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> NO		16. SOCIAL SECURITY NO.		17. INFORMANT		Address									
		NONE		ELSIE HILL NEW WINDSOR MD											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic CVD 422 DUE TO Conditions, If any, which gave rise to Immediate (b) cause (a), stating the (c) underlying cause last. DUE TO															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)															
INTERVAL BETWEEN ONSET AND DEATH years															
20a. MEDICAL CERTIFICATION		2Da. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
19															
21. I certify that (I) (this hospital) attended the deceased from 7/1/50, 19 to 1/25/66, that (I) (we) last saw the deceased alive on 1/24/66 19, and that death occurred at 4:55 AM, from the causes and on the date stated above.															
22a. SIGNATURE M.E. Robertson															
22b. DATE SIGNED 1/25/66															
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS													
ME ROBERTSON		NEW WINDSOR MD													
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/28/1966		23c. NAME OF CEMETERY OR CREMATORIAL MT OLIVE		23d. LOCATION (City, town or county) (State) NEW WINDSOR RURAL MD									
24. FUNERAL DIRECTOR D.D. Hartley & Sons New Windsor		ADDRESS													
						25a. REC'D BY REGISTRAR JAN 28 1966									
						25b. REGISTRAR'S SIGNATURE Charles Judge									

912 submitted

11/2/11

11/2/11

11/2/11

submitted 3.15

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

death certificate be executed within 24 hours after death.

the law requires that th

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
15M 4-64

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE	
CARROLL CO.		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY	
SYKESVILLE, MD.		MARYLAND	
c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			
SPRINGFIELD STATE HOSPITAL			
3. NAME OF DECEASED (Type or print)	First <i>SAMUEL</i>	Middle <i>Himmel</i>	Last <i>Himmel</i>
4. DATE OF DEATH	Month <i>1 - 22 - 66</i>	Day <i>19</i>	Year
5. SEX	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/1/86</i>
9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months <i>79</i>	11. IF UNDER 24 HRS. Days <i>2</i>	12. IF UNDER 24 HRS. Hours <i>21</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <i>LABORER</i>		11. BIRTHPLACE (County & State, or foreign country) <i>NEW YORK STATE</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	13. FATHER'S NAME <i>Moses Himmel</i>		
14. MOTHER'S MAIDEN NAME <i>Unknown</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>unknown</i>		
16. SOCIAL SECURITY NO.	17. INFORMANT	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. <i>4200</i> (b) <i>Arterialsclerotic heart disease</i> DUE TO (c) <i>Generalized Arterialsclerosis</i>			
INTERVAL BETWEEN ONSET AND DEATH days <i>years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>12/31</i> , 19 <i>40</i> , to <i>1/22</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>1/22/66</i> 19 <i>66</i> , and that death occurred at <i>9:15 P.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>SP Wise III</i>	22b. DATE SIGNED <i>1/22/66</i>		
22c. PHYSICIAN'S NAME (Type) <i>Samuel P. Wise 4th</i>	22d. ADDRESS <i>S.S.Hospital, Maryland</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>25 Jan. 1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Druid Ridge Cemetery</i>	23d. LOCATION (City, town or county) (State) <i>Baltimore County, Maryland</i>
24. FUNERAL DIRECTOR <i>Burgee Funeral Home</i>	ADDRESS <i>3631 Falls Road</i>	25a. REC'D BY REGISTRAR <i>FEB 1 1966</i>	25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

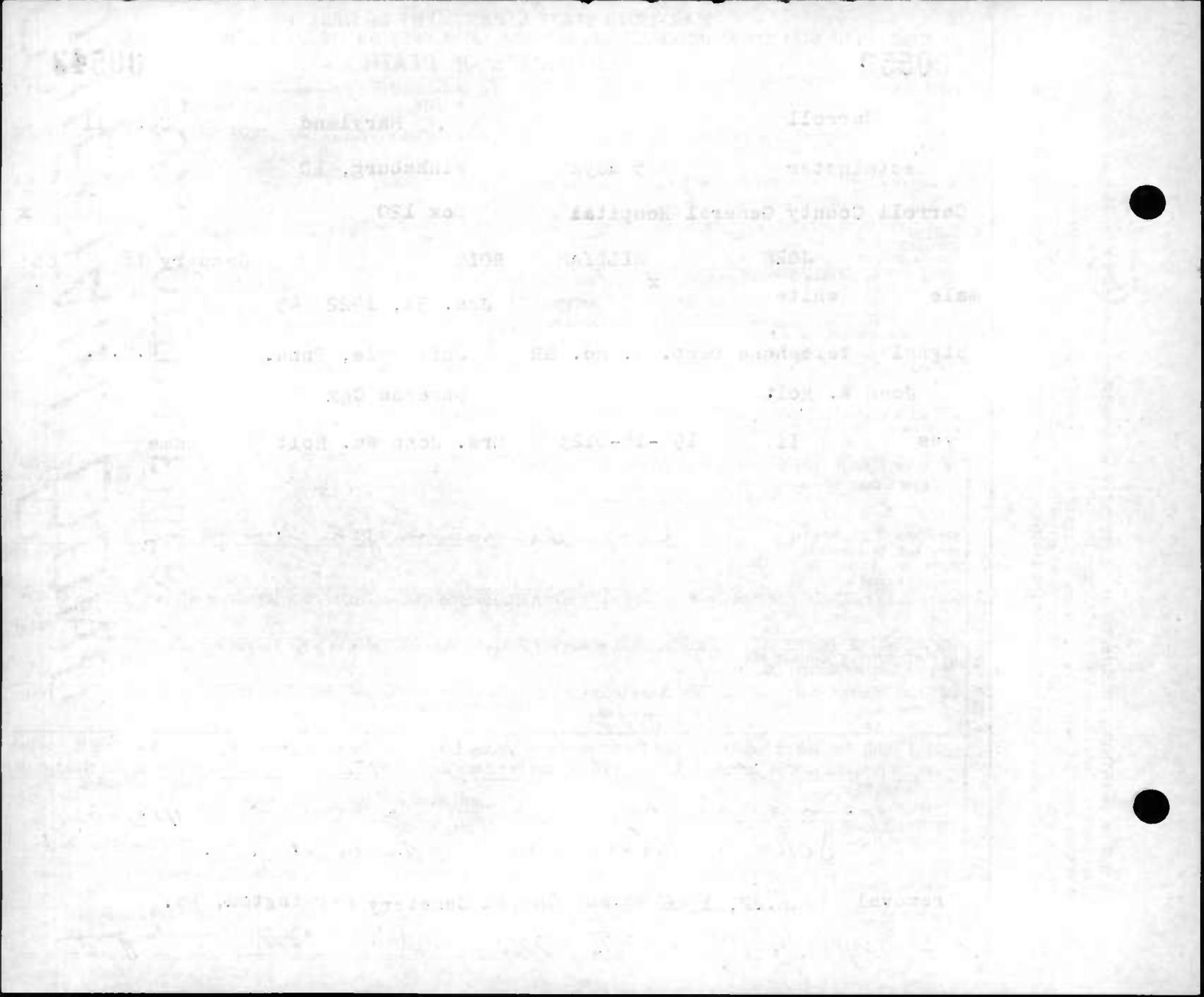
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**00553**

**CERTIFICATE OF DEATH**

**00543**

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Carroll County General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>JOHN</b>	Middle <b>WILLIAM</b>	Last <b>HOLT</b>
4. DATE OF DEATH	Month <b>January</b>	Day <b>18</b>	Year <b>1966</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 31, 1922</b>
9. AGE (In years last birthday) <b>43 yrs.</b>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Signal &amp; Telephone Dept. W. Md. RR</b>	10b. KIND OF BUSINESS OR INDUSTRY <b></b>	11. BIRTHPLACE (County & State, or foreign country) <b>Ohio Pyle, Pnna.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	13. FATHER'S NAME <b>John W. Holt</b>		
14. MOTHER'S MAIDEN NAME <b>Susanna Cox</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes WW II</b>	
16. SOCIAL SECURITY NO. <b>198-18-0123</b>		17. INFORMANT <b>Mrs. John Wm. Holt</b>	Address <b>same</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>2001</b> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO <b>Cancerous growth of the Stomach</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>
20f. (City or town) <b></b>		(County) (State) <b></b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 13, 1966</b> , to <b>Jan 18, 1966</b> , that (I) (we) last saw the deceased alive on <b>Jan 18, 1966</b> , and that death occurred at <b>9 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>John S. Harshey</b>		22b. DATE SIGNED <b>1/18/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN S. HARSHEY, MD</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>8 Anchordt. Westminster, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE THEREOF <b>Jan. 22, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Samson Chapel Cemetery</b>
24. FUNERAL DIRECTOR		ADDRESS <b>J. S. Myers Jr. Westminster, Md.</b>	23d. LOCATION (City, town or county) (State) <b>Farmington, Pa.</b>
25a. REC'D BY REGISTRAR <b></b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	DATE <b>JAN 20 1966</b>



To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and 1 any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY <i>Carroll</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>										
c. LENGTH OF STAY IN 1b <i>Sykesville</i>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>										
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Pullen Nursing Home</i>				d. STREET ADDRESS <i>1329 Dalton Road #34</i>										
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) <i>Anna</i>				First	Middle	Last	4. DATE OF DEATH <i>Jan. 5, 1966</i>	Month	Day	Year				
5. SEX <i>female</i>				6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <i>WIDOWED</i> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 24, 1878</i>	9. AGE (In years last birthday) <i>87 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>home</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Czech.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Frank Korechy</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>none</i>				17. INFORMANT <i>Mary Sikora, dght., above</i>				Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]														
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis generalized, diabetes</i>														
4501 DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Gangrene of left foot</i> 11-28-64 (c) <i>Carcinoma of left cheek</i> 1-5-66														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from Nov. 28, 1964, to Jan 5, 1966, that (I) (we) last saw the deceased alive on Jan. 5, 1966, and that death occurred at 5 A.M. from the causes and on the date stated above.				22b. DATE SIGNED <i>Howard E. Hall</i> Jan. 5, 1966										
22a. SIGNATURE <i>Howard E. Hall</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22d. ADDRESS <i>Sykesville, Maryland</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>1/8/66</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cemetery</i>				23d. LOCATION (City, town or county) (State) <i>Baltimore, Md.</i>		
24. FUNERAL DIRECTOR <i>Schimmele Funeral Home, Inc.</i>				ADDRESS <i>3331 Brehms Lane #13</i>				25a. REC'D BY REGISTRAR <i>JAN 10 1966</i>				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
VR A15 (4) 20M 1/65														

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, it should be detached from the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

00555 00545

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Westminster c. LENGTH OF STAY IN lb 18 Months		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore City 30 - 4	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glover Nursing Home		d. STREET ADDRESS 2623 Cold Spring Lane	
3. NAME OF DECEASED (Type or print) Mamie	First E.	Middle Kagler	4. DATE OF DEATH January 18 1966
5. SEX Female	6. COLOR OR RACE Cau.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH October 11, 1884	9. AGE (in years last birthday) 81 IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Department Store	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland
13. FATHER'S NAME Charles Kagler		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Frank A. Kagler Address 7827 Birmingham Ave. 21234
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebro-vascular accident 25min. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. } (b) DUE TO Arteriosclerosis -- -- -- } (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>May 31, 1964</u> to <u>Jan 18, 1966</u> , that (I) (we) last saw the deceased alive on <u>Jan 12, 1966</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Reese Wilkens</u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>Jan 20 1966</u>
22c. PHYSICIAN'S NAME (Type) <u>E Reese WILKENS</u>		22d. ADDRESS <u>15 Kemper Westminster Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>January 21/66</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Mt. Carmel Cemetery</u>
23d. LOCATION (City, town or county) (State) <u>Baltimore City Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Goff</u>		ADDRESS <u>Hampstead, Maryland</u>	25a. REC'D. BY REGISTRAR DATE <u>JAN 21 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Alma, Judge</u>

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

**00556**

**00546**

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>18 Months</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Mont.</b>	
						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>			
						d. STREET ADDRESS <b>3515 Taylor street</b>			
								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>George Joseph Keating</b>		First	Middle	Last	4. DATE OF DEATH <b>January 9 1966</b>	Month	Day	Year	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>12-9-05</b>	9. AGE (in years last birthday) <b>60 yrs.</b>	10. KIND OF BUSINESS OR INDUSTRY <b>Lawyer</b>	11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Patrick Keating</b>		14. MOTHER'S MAIDEN NAME <b>Frances Cunningham</b>		Address					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. ?		17. INFORMANT <b>Springfield St. Hosp. Records</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>days</b>					
<b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) <b>Coronary arteriosclerosis.</b>			years				
		DUE TO (c) <b>Numerous large gangrenous and infected decubitus ulcers and extreme emaciation.</b>			months				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic brain syndrome of unknown cause without qualifying phrase.</b>		(Parkinson Disease)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Sykesville</b>	(County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>7-8-</b> , 19 <b>64</b> , to <b>I-9-</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>I-9-</b> 19 <b>66</b> , and that death occurred <b>8:35 AM</b> , from the causes and on the date stated above.		22b. DATE SIGNED <b>I-9-66</b>							
22a. SIGNATURE <b>Frances Reid Na bors</b>		M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) <b>Frances Reid Na bors</b>		22d. ADDRESS <b>Sykesville, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>1-11-66 Burial</b>		23b. DATE THEREOF <b>1-11-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Gate of Heaven Cem.</b>	23d. LOCATION (City, town or county) (State) <b>Silver Spring, Md.</b>					
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b>		ADDRESS <b>Bethesda, Maryland</b>	25a. REC'D BY REGISTRAR <b>JAN 13 1966</b>	25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>					

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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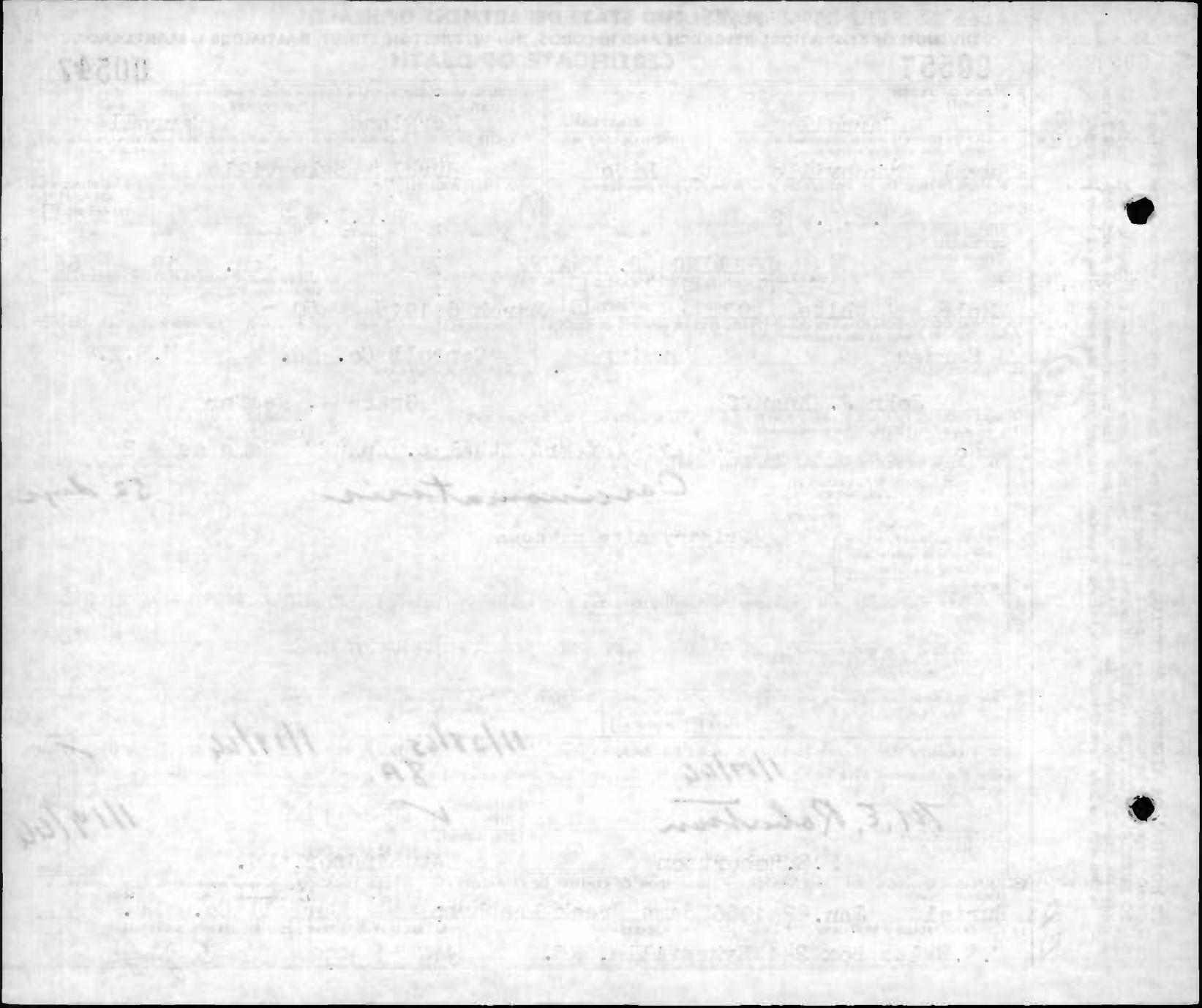
Item 18 Film G375 4 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00557

00547

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
Carroll		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	b. COUNTY Carroll	
Rural Sykesville	Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS Rural Sykesville 06-1	
R.F.D.# 2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First	Middle	Last
STERLING D. KNAUFF			
4. DATE OF DEATH	Month	Day	Year
R.F.D.# 2	Jan.	19	19 66
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	March 6 1915
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Farmer		Farming	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Carroll Co. Md.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John J. Knauff		Grace A. Keefer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)		16. SOCIAL SECURITY NO.	
No		218-14-2994	
17. INFORMANT		Address	
Mrs Ethel S. Knauff		Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		32 days	
1992		Carcinomatosis	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Primary site unknown	
DUE TO (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)			
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
19			20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from.....		11/28/65 19....., to..... 11/9/66 19....., that (I) (we) last saw the deceased alive on..... 11/17/66 19....., and that death occurred at 8 AM, from the causes and on the date stated above.	
22a. SIGNATURE <i>M.E. Robertson</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 11/9/66
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS New Windsor, Md.	
M.E. Robertson			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIAL
Burial		Jan. 22 1966	Sams Creek Brethren
24. FUNERAL DIRECTOR'S SIGNATURE		23d. LOCATION (City, town or county) (State)	
C.M. Waltz Box 241 Sykesville, Md.		Carroll Co. Md.	
ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
DATE JAN 21 1966		j Charles Judge	



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

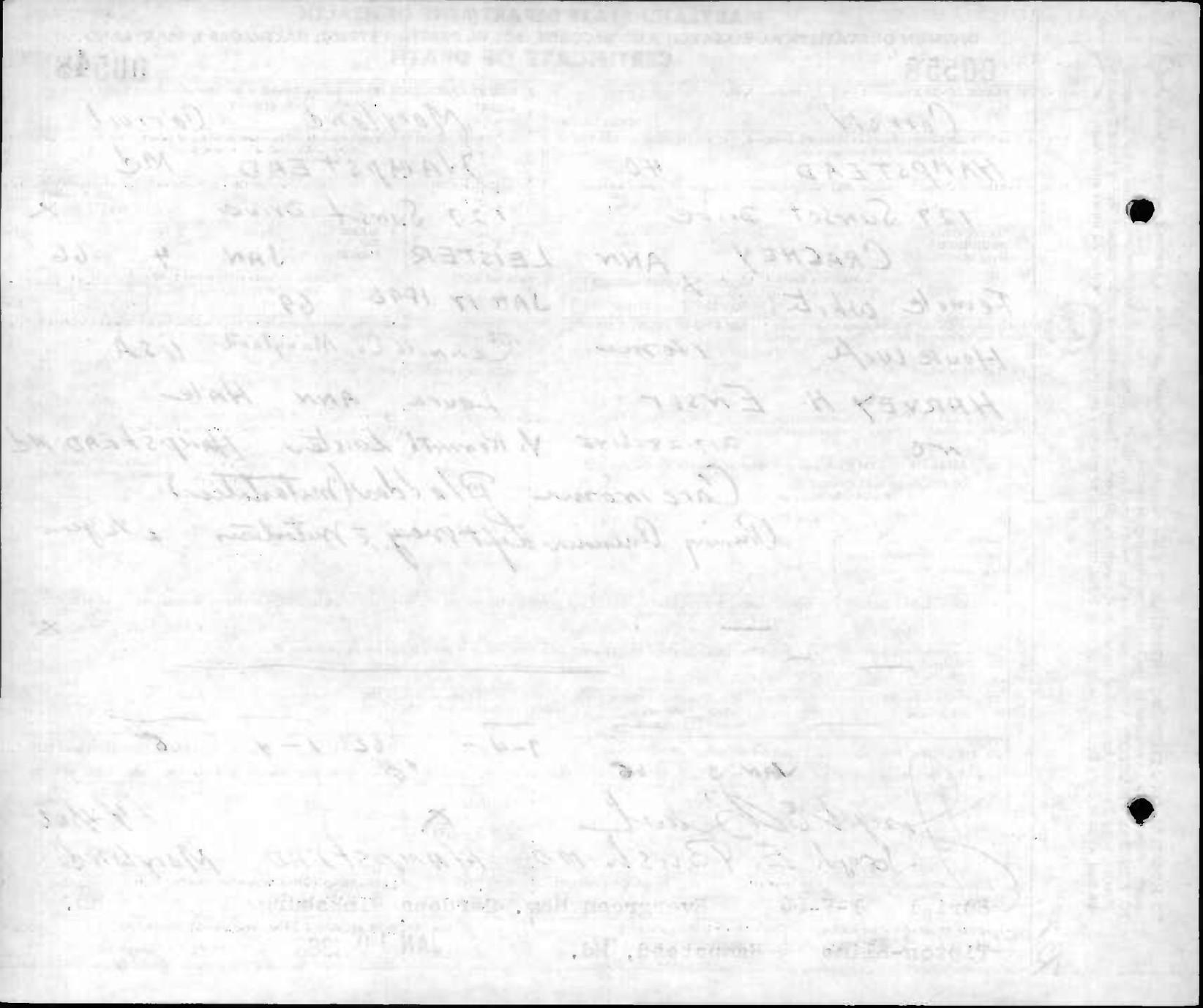
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00558

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the physician or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH e. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)	
<i>Carroll</i>				e. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HAMPSTEAD</i>		c. LENGTH OF STAY IN 1b <i>40</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HAMPSTEAD</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>127 Sunset Drive</i>				d. STREET ADDRESS <i>127 Sunset Drive</i>	
3. NAME OF DECEASED (Type or print) <i>CRACHEY</i>		First	Middle	Last	4. DATE OF DEATH Month <i>JAN</i> Day <i>4</i> Year <i>1966</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Widowed <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>JAN 17 1896</i>		9. AGE (In years last birthday) <i>69 yrs.</i>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Carroll Co., Maryland</i>	
13. FATHER'S NAME <i>HARVEY H. Ensor</i>		14. MOTHER'S MAIDEN NAME <i>Laura ANN Hale</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-28-6145</i>		17. INFORMANT <i>V. Kenneth Lester Hampstead Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>1750</i>		<i>Carcinoma Bladder(metastatic)</i>			
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) } (c)		<i>Pneum Arteria Leftonay, c metastasis</i> 2 1/2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____	(County) (State) _____
21. I certify that (I) (this hospital) attended the deceased from <i>7-4-</i> , 1966 to <i>1-4-</i> , 1966, that (I) (we) last saw the deceased alive on <i>JAN 3</i> , 1966, and that death occurred at <i>Hospital</i> , from the causes and on the date stated above.					
22e. SIGNATURE <i>Joseph E. Bush</i>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>Joseph E. Bush MD</i>		22d. ADDRESS <i>Hampstead Maryland</i>		22b. DATE SIGNED <i>4/4/66</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1-7-66</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Evergreen Mem. Gardens</i>	
23d. LOCATION (City, town or county) <i>Finksburg</i>				(State) <i>MD.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Tipton-Eline</i>		ADDRESS <i>Hampstead, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 10 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



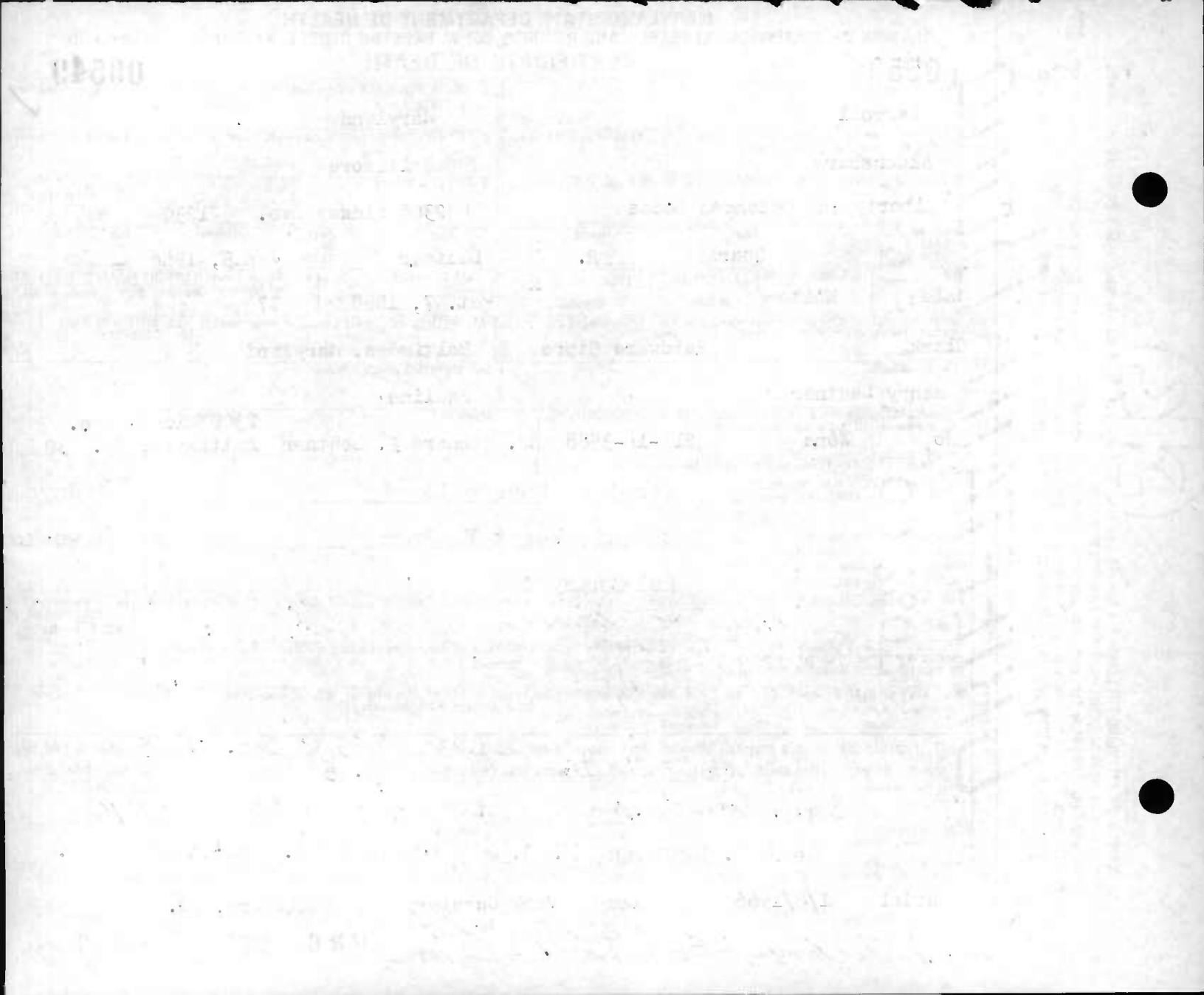
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

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**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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<p>1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND</p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Eldersburg</b></p> <p>c. LENGTH OF STAY IN 1b</p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b></p> <p>b. COUNTY</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b></p> <p>d. STREET ADDRESS <b>2308 Sidney Ave. 21230</b></p>	
<p>3. NAME OF DECEASED (Type or print) <b>Charles R. Leutner</b></p> <p>4. DATE OF DEATH <b>Jan 5, 1966</b></p>		<p>Month <b>Jan</b></p> <p>Day <b>5</b></p> <p>Year <b>1966</b></p>	
<p>5. SEX <b>Male</b></p> <p>6. COLOR OR RACE <b>White</b></p> <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <b>Oct. 7, 1888</b></p> <p>9. AGE (In years last birthday) <b>77 yrs.</b></p> <p>IF UNDER 1 YEAR Months <b>77</b></p> <p>IF UNDER 24 HRS. Odays <b>0</b></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b></p> <p>10b. KIND OF BUSINESS OR INDUSTRY <b>Hardware Store</b></p>		<p>11. BIRTHPLACE (County &amp; State, or foreign country) <b>Baltimore, Maryland</b></p> <p>12. CITIZEN OF WHAT COUNTRY? <b>United States</b></p>	
<p>13. FATHER'S NAME <b>Henry Leutner</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>Pauline</b></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b></p>		<p>16. SOCIAL SECURITY NO. <b>213-14-3588</b></p>	
<p>17. INFORMANT <b>Mr. Richard F. Leutner</b></p>		<p>2500 Address <b>Sidney Ave.</b></p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Pneumonia</b></p>		<p>INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b></p>	
<p>OUE TO (b) <b>Chronic Heart Failure</b></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Pulmonary TBC</b></p>		<p>4 weeks <b>7</b></p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Neylosoclerosis</b></p>			
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.) <b>—</b></p>	
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b></p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p> <p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 23, 1965</b>, to <b>Dec. 31, 1965</b>, that (I) (we) last saw the deceased alive on <b>Jan 5 1966</b> and that death occurred at <b>2:00 PM</b>, from the causes and on the date stated above.</p>			
<p>22a. SIGNATURE <b>Sani Okutman</b></p>		<p>22b. DATE SIGNED <b>1/16/66</b></p>	
<p>22c. PHYSICIAN'S NAME (Type) <b>Sani A. Okutman, M. D.</b></p>		<p>22d. ADDRESS <b>Obrecht Rd. Sykesville, Md.</b></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>23b. DATE THEREOF <b>1/8/1966</b></p>	
<p>23c. NAME OF CEMETERY OR CREMATORIAL <b>Loudon Park Cemetery</b></p>		<p>23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b></p>	
<p>24. FUNERAL DIRECTOR <b>Wm. J. Tickner &amp; Sons Mortuary</b></p>		<p>25a. REC'D BY REGISTRAR <b>JAN 6 1966</b></p>	
<p>25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b></p>			



1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)											
a. COUNTY Carroll MARYLAND				a. STATE Maryland b. COUNTY Washington											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural--Sykesville				c. LENGTH OF STAY IN 1b 6y. 11m. 1d.											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital				Boonesboro 21-2											
3. NAME OF DECEASED First Carrie Middle Edith Last Martz				4. DATE OF DEATH Month 1 Day 18 Year 1966											
Type or print) female white				5. SEX 6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				8. DATE OF BIRTH 9. AGE (In years last birthday) 73 yrs.				10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS Days Hours Min.	
				WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				4/8/92							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Franklin Bowers				14. MOTHER'S MAIDEN NAME Jennie Sumam				Address							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none				17. INFORMANT Springfield Hospital records, Sykesville				INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO <i>Cardiovascular Failure</i> Conditions, If any, which gave rise to Immediate (b) b) Senility. cause (a), stating the (c) <i>Hypocardial Infarction</i> underlying cause last.															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Chronic brain syndrome of unknown or unspecified cause with psychotic reaction.</i>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2/17/1959 to 1/18/1966, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 1/18/1966, and that death occurred at 6:45 P.M. from the causes and on the date stated above.												22b. DATE SIGNED 1/18/66			
22a. SIGNATURE <i>Fausto Acosta Natal</i>				M.O. ATTENDING PHYS. <input type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>								22b. ADDRESS Springfield State Hospital Sykesville, Maryland			
22c. PHYSICIAN'S NAME (Type) Fausto Acosta Natal, M.D.				23d. LOCATION (City, town or county) Boonesboro, Md. (State)											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Jan 20 66				23c. NAME OF CEMETERY OR CREMATORIUM Boonesboro Cemetery				23d. LOCATION (City, town or county) Boonesboro, Md. (State)			
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Baptist Funeral Home, Takoma Park, Md.								DATE JAN 24 1966				Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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00561

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00551

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>3 yrs. 7 mos. 7 dys.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>3401 Menlo Drive</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>IRVIN</b>	Middle <b>JOSEPH</b>	Last <b>McCURRY</b>	4. DATE OF DEATH <b>JANUARY 21 1966</b>	Month Day Year				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-16-11</b>	9. AGE (In years last birthday) <b>54 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Painter</b>	10b. KIND OF BUSINESS OR INDUSTRY <b></b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John A. McCurry</b>			14. MOTHER'S MAIDEN NAME <b>Mary L. Cullen</b>						
15. WAS DEC EASSED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Records, Springfield State Hospital</b>	Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral lobar pneumonia</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>					
490X Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO									
(c) DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Schizophrenic reaction, simple type</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Baltimore</b>	(County) <b>Md.</b>	(State) <b></b>			
21. I certify that (I) (this hospital) attended the deceased from <b>6-14-35</b> , 19 <b>19</b> , to <b>1-21-66</b> , 19 <b>19</b> , that (I) (we) last saw the deceased alive on <b>1-21-66</b> 19 <b>19</b> , and that death occurred at <b>2:30 AM</b> , from the causes and on the date stated above.						22b. DATE SIGNED <b>Jan 21 1966</b>			
22a. SIGNATURE <b>Frances Reid Nabors,</b>		M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) <b>Frances Reid Nabors, M. D.</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-24-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Loudon Park Cemetery</b>	23d. LOCATION (City, town or county) <b>Baltimore, Md.</b>	(State)				
24. FUNERAL DIRECTOR <b>Vernon Lemmon Park Heights Ave</b>		ADDRESS <b>130 Vernon Lemmon Park Heights Ave</b>	25a. REC'D BY REGISTRAR <b>AN 25 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					
VR A15 (4) 20M 1/65									

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after

death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00562

00552

1. PLACE OF DEATH  
a. COUNTY

Carroll

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Manchester

c. LENGTH OF STAY IN 1b

2 years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Long View Nursing Home Inc

3. NAME OF  
DECEASED  
(Type or print)

Last

Middle

McNamee

First

Ada

4. DATE  
OF  
DEATH  
Jan 26 1966

## 5. SEX

Female

## 6. COLOR OR RACE

White

7. MARRIED  
WIDOWED  DIVORCED 

## 8. DATE OF BIRTH

Jan 16, 1885

9. AGE (In years  
last birthday) 81 yrs.

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

## 10b. KIND OF BUSINESS OR INDUSTRY

—

## 11. BIRTHPLACE (County &amp; State, or foreign country)

Baltimore Co. Maryland

## 12. CITIZEN OF WHAT COUNTRY?

USA

## 13. FATHER'S NAME

Frank P Gore

## 14. MOTHER'S MAIDEN NAME

Mary E. Gore

Address New Freedom, Pa.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  NO

## 16. SOCIAL SECURITY NO.

198362854 Mrs Helen Hedrick

## 17. INFORMANT

Address

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

260 X

DUE TO

(b)

DUE TO

(c)

1) Arteriosclerotic Cardio Vascular Disease 5 yrs

2) Diabetes mellitus — 5 yrs

INTERVAL BETWEEN  
ONSET AND DEATH5 yrs  
5 yrs19. WAS AUTOPSY PERFORMED?  
YES  NO 20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

Quandice —

## 20c. TIME OF INJURY Month, Day, Year

Hour e.m.

p.m.

20d. INJURY OCCURRED

While at work  Not While at work 

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

19

## 21. I certify that (1) (this hospital) attended the deceased from Feb. 1964 to Jan 26, 1966, that (1) (we) last saw the deceased alive on 1/22, 1966, and that death occurred at 3:30 A.M. from the causes and on the date stated above.

## 22a. SIGNATURE

W. H. Ford

ATTENDING PHYS.  MED. DIRECTOR  STAFF PHYS. 

## 22b. DATE SIGNED

## 22c. PHYSICIAN'S NAME (Type)

W. H. Ford M.D.

22d. ADDRESS

MANCHESTER, PA. 1/26/66

## 23a. BURIAL, CREMATION, REMOVAL (Specify)

## 23b. DATE THEREOF

## 23c. NAME OF CEMETERY OR CREMATORIAL

## 23d. LOCATION (City, town or county)

## (State)

## 23e. FUNERAL DIRECTOR'S SIGNATURE

## ADDRESS

## 25a. RECEIVED BY REGISTRAR

## 25b. REGISTRAR'S SIGNATURE

FEB 1 1966

DATE

800

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

110553

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pages 1 and 2 <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>28 yrs. lmo. 25 dys.</b> d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		e. STREET ADDRESS <b>1508 Marshall St.</b>	
3. NAME OF DECEASED (Type or print) <b>LORETTA</b>		First <b>(NMN)</b> Middle <b>(NMN)</b> Last <b>McNAMEE</b>	4. DATE OF DEATH <b>JANUARY 12</b> Month <b>19</b> Year <b>66</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-1-01</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>61</b> yrs. 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>George McNamee</b>		14. MOTHER'S MAIDEN NAME <b>Anna Tighe</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Records, Springfield State Hospital</b> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>4221</b> Years			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) DUE TO (c)	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <b>Chronic brain syndrome assoc. with convulsive disorder, with psychotic reaction</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED at work <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11-17-37</b> , 19 <b>00</b> , to <b>1-12-66</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>1-12-66</b> , 19 <b>66</b> , and that death occurred at <b>9:00 AM</b> , from the causes and on the date stated above.		22b. DATE SIGNED <b>1-13-66</b>	
22a. SIGNATURE <b>Dr. Antonius Glahn</b>		ATTENDING M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Antonius Glahn, M. D.</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>	
23a. BURIAL / CREMATION, REMOVAL (Specify) <b>1/15/66</b>		23b. DATE THEREOF <b>1/15/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Cathedral</b> 23d. LOCATION (City, town or county) <b>Baltimore</b> (State)
24. FUNERAL DIRECTOR <b>Joe Kelly - 130 E. Foote St.</b>		ADDRESS <b>Joe Kelly - 130 E. Foote St.</b>	25a. REC'D BY REGISTRAR <b>W N 17 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>
VR A15 (4) 20M 1/65		DATE	

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

100554

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster</i>		c. LENGTH OF STAY IN 1b <i>100-a.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Carroll County General Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>HARRY</i>	Middle <i>PAUL</i>	Last <i>MORELOCK</i>
4. DATE OF DEATH <i>JANUARY 30 1966</i>	Month	Day	Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 16 1893</i>
9. AGE (In years last birthday) <i>72 yrs.</i>	10. IF UNDER 1 YEAR Months <i>11</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Carroll Co. Maryland U.S.A.</i>	
13. FATHER'S NAME <i>Jacot O. Morelock</i>	14. MOTHER'S MAIDEN NAME <i>Elizabeth Giggard</i>	12. CITIZEN OF WHAT COUNTRY? <i>-</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>-</i>	16. SOCIAL SECURITY NO. <i>-</i>	17. INFORMANT <i>Mrs Ruth R. Morelock, Same</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> DUE TO <i>arteriosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>10 min</i>			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>-</i> (c) <i>-</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>-</i>
20f. (City or town) <i>-</i>		(County) <i>-</i>	(State) <i>-</i>
21. I certify that (I) (this hospital) attended the deceased from <i>Jan. 1, 1966</i> to <i>Jan 28, 1966</i> , that (I) (we) last saw the deceased alive on <i>Jan 26, 1966</i> , and that death occurred at <i>1 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>E. Reese Wilkens</i>			
22b. DATE SIGNED <i>Feb 1, 1966</i>		22c. PHYSICIAN'S NAME (Type) <i>E. Reese Wilkens</i>	22d. ADDRESS
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2/3/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Kreider Cemetery</i>
24. FUNERAL DIRECTOR <i>J. S. Myers, Jr., Westminster, Md.</i>		ADDRESS	23d. LOCATION (City, town or county) <i>Rural, Westminster, Md.</i>
25a. REC'D BY REGISTRAR <i>FEB 3 1966</i>		25b. REGISTRAR'S SIGNATURE <i>James J. ...</i>	

12200

HTS&C 10-1964

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1. In the first place, we must have a clear understanding of what we mean by "education".  
2. We must have a clear understanding of what we mean by "the individual".  
3. We must have a clear understanding of what we mean by "the family".  
4. We must have a clear understanding of what we mean by "the community".  
5. We must have a clear understanding of what we mean by "the nation".  
6. We must have a clear understanding of what we mean by "the world".

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**00565**

**CERTIFICATE OF DEATH**

Item #7 Form #G372-2176 PC

**00555**

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>40 yrs. 10 mos. 9 dys.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>ALICE</b>	Middle <b>MORGAN</b>	Last <b>ODENSAUS</b>
4. DATE OF DEATH Month <b>JANUARY</b>	Day <b>21</b>	Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/13/1879</b>
9. AGE (In years last birthday) <b>86 (?) yrs.</b>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(none)</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	13. FATHER'S NAME <b>Charles Morgan</b>		
14. MOTHER'S MAIDEN NAME <b>(unknown)</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) <b>no</b>		
16. SOCIAL SECURITY NO. <b>(none)</b>	17. INFORMANT <b>Records, Springfield State Hospital</b>	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  <b>4201</b>	INTERVAL BETWEEN ONSET AND DEATH hours  <b>Coronary occlusion</b>		
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.  <b>Arteriosclerotic cardiovascular disease</b>	years		
DUE TO (b)  DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  <b>Schizophrenic reaction plus mental retardation</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Boudon Park Cem</b>	20f. (City or town) (County) (State) <b>Baltimore 29</b>
21. I certify that <b>Ilse Kamm</b> attended the deceased from <b>March 12, 1925</b> to <b>Jan. 21, 1966</b> , that <b>Ilse Kamm</b> last saw the deceased alive on <b>Jan. 21, 1966</b> , and that death occurred at <b>1:45 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE  <b>Ilse Kamm</b>	22b. DATE SIGNED  <b>Jan. 21, 1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>Ilse Kamm, M.D.</b>	M.D. ATTENDING PHYS. <input type="checkbox"/> 22d. ADDRESS <b>Sykesville, Md.</b>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1-22-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Boudon Park Cem</b>	23d. LOCATION (City, town or county) (State) <b>Baltimore 29</b>
24. FUNERAL DIRECTOR <b>Mc Cully Funeral Home 237 Patapsco Ave</b>	ADDRESS <b>237 Patapsco Ave</b>	25a. REC'D BY REGISTRAR <b>JAN 25 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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verso la fine di aprile

l'arrivo di un nuovo

(grande)

(grado)

l'arrivo di un nuovo

arrivo di un nuovo

comitato di governo

verso la fine di aprile

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00566

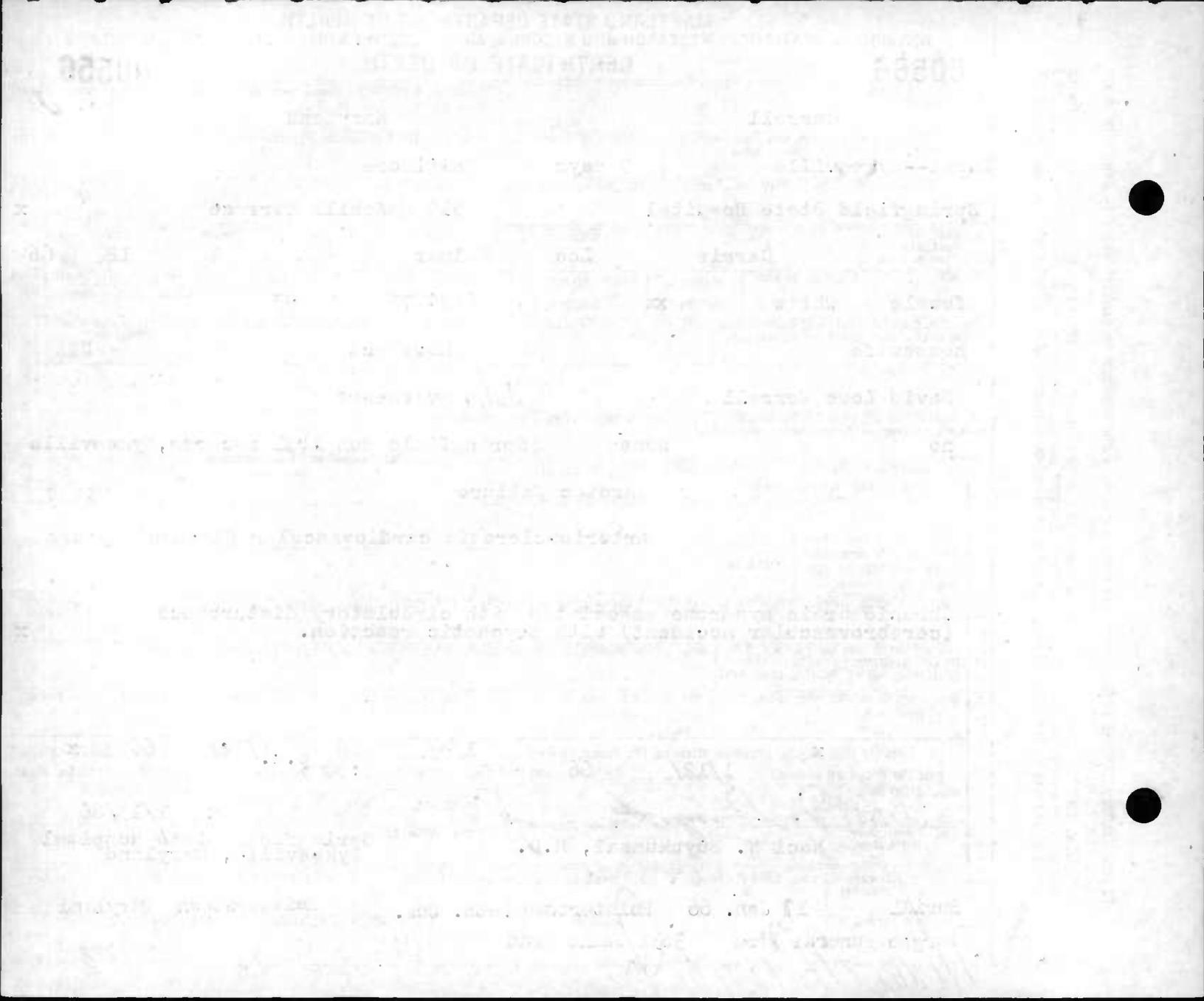
## CERTIFICATE OF DEATH

10556

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
Rural--Sykesville		7 days		Baltimore					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Springfield State Hospital				517 Rosehill Terrace		30 - 4			
3. NAME OF DECEASED (Type or print)		First Carrie	Middle Lee	Last Palmer	4. DATE OF DEATH	Month 1	Day 12	Year 1966	
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6/27/72	9. AGE (In years last birthday) 93 yrs.	IF UNOER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME David Lowe Worrell		14. MOTHER'S MAIDEN NAME Julia Everheart							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none		17. INFORMANT Springfield Hospital records, Sykesville		Address			
no									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure									
4221 4221 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease									
DUE TO (b) DUE TO (c) years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with circulatory disturbance (cerebrovascular accident) with psychotic reaction.									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that <input type="checkbox"/> (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that <input type="checkbox"/> (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____, from the causes and on the date stated above.		1/5/1966 to 1/12/1966							
22a. SIGNATURE <i>Naci N. Buyukunsal</i>		22b. DATE SIGNED 1/13/66							
22c. PHYSICIAN'S NAME (Type) Naci N. Buyukunsal, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 17 Jan. 66		23c. NAME OF CEMETERY OR CREMATORIAL Reisterstown Meth. Cem.		23d. LOCATION (City, town or county) (State) Reisterstown Maryland			
24. FUNERAL DIRECTOR Burgee Funeral Home		ADDRESS 3631 Falls Road				25a. REC'D BY REGISTRAR JAN 17 1966			
						25b. REGISTRAR'S SIGNATURE Charles Judge			



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00567

## CERTIFICATE OF DEATH

00557

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural--Sykesville</b>		b. COUNTY <b>Montgomery</b>	
c. LENGTH OF STAY IN 1b <b>16 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>5808 Marbury Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Mildred</b>	Middle <b>Susan</b>	Last <b>Paul</b>
4. DATE OF DEATH	Month <b>1</b>	Day <b>16</b>	Year <b>1966</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/21/78</b>
9. AGE (In years last birthday) <b>87 yrs.</b>	10. IF UNDER 1 YEAR Months <b>6</b>	11. IF UNDER 24 HRS. Days <b>25</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Richard White</b>	14. MOTHER'S MAIDEN NAME <b>unknown Pegram</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Springfield Hospital records, Sykesville</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b>			
4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b>			
DUE TO (c) <b>Bronchopneumonia</b>			
DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic brain syndrome associated with senile brain disease with psychotic reaction.</b>			
INTERVAL BETWEEN ONSET AND DEATH Weeks Years Days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Springfield State Hospital</b>
20f. (City or town) <b>Sykesville</b>		(County) (State) <b>Maryland</b>	
21. I certify that <b>(I)</b> (this hospital) attended the deceased from <b>12/30/ 1965</b> , to <b>1/16/ 1966</b> , that <b>(we)</b> last saw the deceased alive on <b>1/16/ 1966</b> , and that death occurred at <b>8:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>R. G. Lajonchere MD</b>		22b. DATE SIGNED <b>1/16/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Rinaldo G. Lajonchere, M.D.</b>		M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-19-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Parklawn Cemetery</b>
24. FUNERAL DIRECTOR <b>Robert G. Humphrey</b>		ADDRESS <b>Bethesda, Md.</b>	25a. LOCATION (City, town or county) <b>Rockville, Maryland</b>
25b. REGISTRAR'S SIGNATURE <b>G. Clinches Judge</b>		DATE <b>JAN 20 1966</b>	25a. REC'D BY REGISTRAR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Second

Wheat Ridge

Second

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												00558							
CERTIFICATE OF DEATH																			
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)															
a. COUNTY		Carroll		MARYLAND		a. STATE		Maryland		b. COUNTY		Washington							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Sykesville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Hagerstown		d. STREET ADDRESS		21 - 2							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				143 W. Franklin Street								e. IS RESIDENCE ON A FARM?							
Springfield State Hospital												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First	Middle	Last		4. DATE OF DEATH		Month		Day		Year							
Female		HELEN	MARY	RAMSEY		JANUARY 18 1966													
5. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.							
Female		White		WIDOWED <input checked="" type="checkbox"/>		3-23-90		75 yrs.		Months		Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?							
Nurse				Nursing				Pennsylvania				U.S.A.							
13. FATHER'S NAME (unknown)				14. MOTHER'S MAIDEN NAME (unknown)				Address											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				Records, Springfield State Hospital							
No				None															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH a week							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia																			
4221 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.												(b) Arteriosclerotic cardiovascular disease years							
(c)																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome associated with senile brain disease with psychotic reaction.												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)							
19																			
21. I certify that (I) this hospital attended the deceased from March 17, 1960, to Jan. 18, 1966, that (I) we last saw the deceased alive on Jan. 18, 1966, and that death occurred at 5:50 P.M. from the causes and on the date stated above.												22b. DATE SIGNED 1-18-66							
22a. SIGNATURE Ilse Kamm, M.D.												22b. DATE SIGNED 1-18-66							
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS Sykesville, Maryland															
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF 1-27-66		23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's		23d. LOCATION (City, town or county) Anne Arundel P.A.				(State)							
Burial																			
24. FUNERAL DIRECTOR				ADDRESS Burke A. Haught Sykesville, Md.								25a. REC'D BY REGISTRAR DATE JAN 20 1966				25b. REGISTRAR'S SIGNATURE John Wesley Judge			

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00569

CERTIFICATE OF DEATH

00559

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>5 MONTHS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>		d. STREET ADDRESS <b>180 Washington Rd.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ANDREW JACKSON</b>		First	Middle	Last	4. DATE OF DEATH <b>Jan. 1 1966</b>	Month	Day	Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIOOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-1-83</b>	9. AGE (In years last birthday) <b>82</b>	10. IF UNDER 1 YEAR <input type="checkbox"/> Months <b>0</b>	11. IF UNDER 24 HRS. <input type="checkbox"/> Days <b>0</b>	12. IF UNDER 24 HRS. <input type="checkbox"/> Hours <b>0</b>	13. IF UNDER 24 HRS. <input type="checkbox"/> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Frank Raver</b>		14. MOTHER'S MAIDEN NAME <b>MARY E. -3</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-36-4893</b>			
17. INFORMANT <b>Records Springfield Hosp. Sykesville, Md.</b>		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>Bronchopneumonia</b>		INTERVAL BETWEEN DEATH AND DEATH Days			
IMMEDIATE CAUSE (a) <b>715X</b>		DUE TO <b>Infected Decubitus Ulcers</b>				Weeks			
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b)									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CBS Associated with senile brain disease with psychotic reaction</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>(County)</b> (State)
p.m.									
21. I certify that (I) (this hospital) attended the deceased from <b>7-9-65</b> to <b>1-1-66</b> , 19, that (I) (we) last saw the deceased alive on <b>1-1-66</b> 19, and that death occurred at <b>12:05</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>J.P. Wise Jr.</b>		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1-1-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>S.P. Wise III, M.D.</b>		22d. ADDRESS <b>Sykesville, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1/4/66</b>		23c. NAME OF CEMETERY OR CREMATORIES <b>WESTMINSTER CEM</b>		23d. LOCATION (City, town or county) (State) <b>WESTMINSTER MD.</b>			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR <b>JAN 3 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

00570 00560

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>4 yrs. 4 mos. 13 days.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>ALVIN</b>	Middle <b>ANDREW</b>	Last <b>SADLER</b>
4. DATE OF DEATH <b>JANUARY 26 1966</b>	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-8-1897</b>
<b>White</b>	<b>Male</b>	<b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <b>68 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Reined</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Anton Sadler</b>	14. MOTHER'S MAIDEN NAME <b>Ida Klarner</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>215-03-9151</b>	17. INFORMANT <b>Records, Springfield State Hospital</b>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b>			
332X DUE TO (b) <b>Cerebral arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH Days Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.			
DUE TO (c) <b>Generalized arteriosclerosis</b> Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CBS with circulatory disturbance other than cerebral arteriosclerosis, with psychotic reaction. G.I. bleeding.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from <b>9-13-61</b> , 19, to <b>1-26-66</b> , 19, that (I) (we) last saw the deceased alive on <b>1-26-66</b> , 19, and that death occurred at <b>10:00 AM</b> . From the causes and on the date stated above.			
22a. SIGNATURE <i>Octavio A. Ruiz</i>		22b. DATE SIGNED <b>1-26-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Octavio A. Ruiz, M. D.</b>	M.D. <input type="checkbox"/> ATTENDING PHYS. 22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 25a. REC'D BY REGISTRAR <b>Philip Herwig Sons Orleans St</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan 29/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Gardens of Faith</b>	23d. LOCATION (City, town or county) (State) <b>Baltimore Md</b>
24. FUNERAL DIRECTOR <b>Philip Herwig Sons Orleans St</b>	ADDRESS <b>2024</b>	25a. REC'D BY REGISTRAR <b>DATE FEB 1 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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Indoor office equipment - IBM 15-005

Attachment required

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00571

## CERTIFICATE OF DEATH

Item #9 Film #G373 24/166 no

00561

## 1. PLACE OF DEATH

e. COUNTY

Carroll.

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Woodbine

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

e. STATE

Md.

b. COUNTY

Carroll

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Woodbine

06-1

d. STREET ADDRESS

6429 Cedonia Avenue #6

e. IS RESIDENCE  
ON A FARM?YES  NO 3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

Month

Day

Year

Jan 26 1966

## 5. SEX

6. COLOR OR RACE

7. MARRIED  NEVER MARRIED 

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.

Female

WIDOWED DIVORCED 

12-17-1891

170 yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

## 10b. KIND OF BUSINESS OR INDUSTRY

Housewife

## 11. BIRTHPLACE (County &amp; State, or foreign country)

Baltimore Md.

## 12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME

George Easter

## 14. MOTHER'S MAIDEN NAME

Caroline Seckle

Address

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

No

## 16. SOCIAL SECURITY NO.

220-34-6873

## 17. INFORMANT

Mr Henry Schmidt 1911 Leyden Road Timonium

## 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]

PART I. DEATH WAS CAUSED BY,  
IMMEDIATE CAUSE (e)

332X

DUE TO

Conditions, if any, which  
give rise to immediate cause  
(e), stating the underlying  
cause last.

(b)

DUE TO

(c)

Cerebral Vasculitis Occlusion      1  
Card. Asthma & clerosis      9  
Hyperglycemia      9INTERVAL BETWEEN  
ONSET AND DEATH

## MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m.  
p.m. 1920d. INJURY OCCURRED  
While  Not While   
at work  at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)20f. (City or town)  
(County) (State)21. I certify that (I) (this hospital) attended the deceased from June 22 1963 to Jan 26 1966 that (I) (we) last  
saw the deceased alive on Jan 26 1966 and the death occurred 3360 M, from the causes and on the date stated above.

## 22a. SIGNATURE

H. H. Martin

M.D.

22b. DATE  
SIGNED22c. PHYSICIAN'S  
NAME (Type)

H. H. Martin

ATTENDING  
PHYS.MED.  
DIRECTORSTAFF  
PHYS.23a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

## 23b. DATE THEREOF

1-29-1966

## 23c. NAME OF CEMETERY OR CREMATORIUM

Western Cemetery

## 23d. LOCATION (City, town or county)

Baltimore City

(State)

## 24 FUNERAL DIRECTOR'S SIGNATURE

Lassahn Funeral Home 7401 Belair Road (36)

## ADDRESS

## 25a. REC'D BY REGISTRAR

FEB 1 1966

## 25b. REGISTRAR'S SIGNATURE

Charles Judge

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH						00562								
1. PLACE OF DEATH a. COUNTY			MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)			a. STATE b. COUNTY					
Carroll						Maryland Carroll								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster			c. LENGTH OF STAY IN 1b 2 weeks			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Carroll County General Hospital						d. STREET ADDRESS 14 Webster Street								
3. NAME OF DECEASED (Type or print)		First AGNES	Middle B.	Last SCHWEIGART	4. DATE OF DEATH Jan. 1, 1966		Month	Day	Year					
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1882	9. AGE (in years last birthday) 83 yrs.	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Carroll County, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife														
13. FATHER'S NAME William H. Bankert						14. MOTHER'S MAIDEN NAME Annie R. Reigle								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) ---		16. SOCIAL SECURITY NO. ---		17. INFORMANT		Address 414 Spring St. Martinsburg, Pa.								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Conditions, if any, which gave rise to Immediate (b) cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral vascular insufficiency														
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
		20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not White at work <input type="checkbox"/> p.m. 19			20d. INJURY OCCURRED <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 20, 1965, to Jan 1, 1966, that (I) (we) last saw the deceased alive on Jan 1, 1966, and that death occurred at 7 P.M. from the causes and on the date stated above.														
22a. SIGNATURE John S. Harshey		22b. DATE SIGNED 1/1/66												
22c. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, M.D.		22d. ADDRESS 8 Archibald St. Westminster, Md.												
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF Jan. 4, 1966		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City, town or county) Westminster		(State)						
24. FUNERAL DIRECTOR J. E. Myers, Jr., Westminster, Md.						25a. REC'D BY REGISTRAR JAN 5 1966		25b. REGISTRAR'S SIGNATURE						

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00573

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00563

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>		b. COUNTY <b>Xecondix</b>	
c. LENGTH OF STAY IN 1b <b>30 - 4</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Strand Ave., Rt. 5.</b>		d. STREET ADDRESS <b>3121 Pelham Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>JOHN</b>	Middle <b>ALFRED</b>	Last <b>SHEPPARD</b>
4. DATE OF DEATH	Month <b>January</b>	Day <b>31</b>	Year <b>1966</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/8/1890</b>
9. AGE (in years last birthday) <b>75</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Geo. Franke &amp; Sons</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles Sheppard</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service) <b>yes WW 1</b>		16. SOCIAL SECURITY NO. <b>215-09-2115</b>	
17. INFORMANT		Address <b>Ruth Smoot Sheppard, wife, above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis (acute)</b> INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>			
4201 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> (c) <b>Alcoholism mild</b> 15 yrs.			
9 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20e. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Alphonse Schimunek</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town, or County) <b>3331 Brehms Lane</b>	
22. DATE SIGNED <b>1-31-66</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/4/66</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Balto. Nat. Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>		ADDRESS <b>3331 Brehms Lane</b>	
25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
DATE <b>2 1966</b>			



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00574

CERTIFICATE OF DEATH

111564

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b> Maryland</b>		b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>3mos.12dys.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		30-4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>2216 Garrison Blvd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>NELSON</b>	Middle <b>ROGER</b>	Last <b>SHOWACRE</b>	4. DATE OF DEATH <b>JANUARY 28 1966</b>	Month Day Year				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-18-06</b>	9. AGE (in years last birthday) <b>59 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shop worker/radio repairman</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Nelson Showacre</b>				14. MOTHER'S MAIDEN NAME <b>Elma D. Schneidereith</b>				Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Records, Springfield State Hospital</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia, organism undetermined</b> INTERVAL BETWEEN ONSET AND DEATH Days <b>455X</b>									
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Multiple gangrenous infected decubitus ulcers</b> Weeks (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>10-16-65</b> , 19, to <b>1-28-66</b> , 19, that (I) (we) last saw the deceased alive on <b>1-28-66</b> , 19, and that death occurred at <b>3:35 AM</b> , from the causes and on the date stated above.		22b. DATE SIGNED <b>1-28-66</b>							
22a. SIGNATURE <i>Octavio A. Ruiz</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>							
22c. PHYSICIAN'S NAME (Type) <b>Octavio A. Ruiz, M.D.</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/31/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Dund Ridge</b>		23d. LOCATION (City, town or county) (State) <b>Pikeville, Maryland</b>			
24. FUNERAL DIRECTOR <b>Wm J. Dickenson Jr.</b>		ADDRESS <b>Baltimore, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 1 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00575

CERTIFICATE OF DEATH

00565

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>		c. LENGTH OF STAY IN 1b <b>53 yrs</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>61 Westmoreland Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>ELIZABETH</b>	Middle <b>ANN</b>	Last <b>SNADER</b>	
4. DATE OF DEATH Month <b>January</b>	Day <b>9,</b>	Year <b>1966</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIOOWEO</b> <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>May 26, 1865</b>	
9. AGE (In years last birthday) Months <b>100</b>	10. KIN OF BUSINESS OR INDUSTRY <b>housewife</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Carroll Co., Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Royer</b>	14. MOTHER'S MAIDEN NAME <b>Elizabeth Geiman</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)		
16. SOCIAL SECURITY NO.	17. INFORMANT <b>Miss Edith R. Snader</b>	Address <b>same</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia Bronchitis</b> 1443X DUE TO <b>Chronic Myocarditis (Heart Block)</b> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis + Hypertension</b> DUE TO <b>yes</b> (c) <b>yes</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)				INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>Several yrs</b> <b>Several yrs</b> <b>yes</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Westminster</b>	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May 11, 1963</b> to <b>Aug 1, 1966</b> , that (I) (we) last saw the deceased alive on <b>July 9, 1966</b> , and that death occurred at <b>7:30 AM</b> from the causes and on the date stated above.	22b. DATE SIGNED <b>1-10-66</b>			
22a. SIGNATURE <b>W. Lewis Speicher</b>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <b>Westminster Md</b>	M.E. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>1/12/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Meadow Branch Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>nr Westminster, Maryland</b>	
24. FUNERAL DIRECTOR <b>J. E. Myers, Jr. Westminster, Md</b>	ADDRESS	25a. REC'D BY REGISTRAR <b>OCT 12 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**00576**

**CERTIFICATE OF DEATH**

**00566**

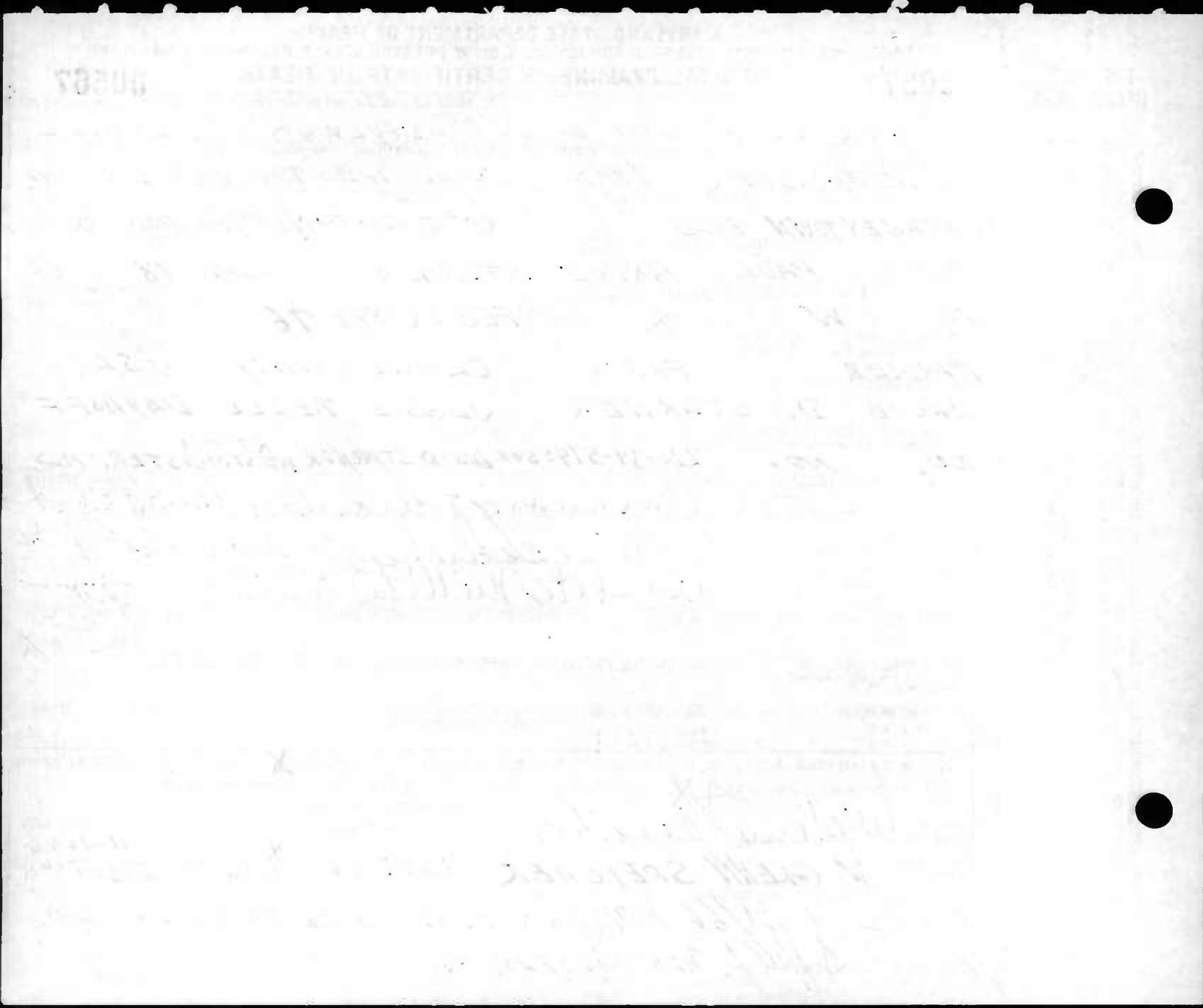
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>9yrs. 9mos. 11days.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Westminster</b> At # 606-1						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS						
3. NAME OF DECEASED (Type or print)		First <b>JOHN</b>	Middle <b>WILLIAM</b>	Last <b>SPENCER</b>	4. DATE OF DEATH <b>JANUARY 17 1966</b>	Month	Day	Year
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>5-27-1885</b>	9. AGE (In years last birthday) <b>80 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pipe fitter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Perma. Railroad</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>James P. Spencer</b>				14. MOTHER'S MAIDEN NAME <b>Mary Evans</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No		None		Records, Springfield State Hospital				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>								
4200 DUE TO (b) <b>Arteriosclerotic heart disease</b>								
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.								
DUE TO (c) <b>Generalized arteriosclerosis</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CBS assoc. with cerebral arteriosclerosis, without qualifying phase</b>								
INTERVAL BETWEEN ONSET AND DEATH Days								
Years								
Years								
20a. MEDICAL CERTIFICATION		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>4-6-56</b> , 19, to <b>1-17-66</b> , 19, that (I) (we) last saw the deceased alive on <b>1-17-66</b> , 19, and that death occurred at <b>9:45 AM</b> , from the causes and on the date stated above.		22b. DATE SIGNED <b>1-17-66</b>						
22a. SIGNATURE <i>Octavio A. Ruiz</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 1-17-66						
22c. PHYSICIAN'S NAME (Type) <b>Octavio A. Ruiz, M. D.</b>		22d. ADDRESS <b>Springfield State Hospital</b> <b>Sykesville, Maryland</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/10/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>St Marys Prot. Episcopal Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hampden Baltimore Md.</b>		
24. FUNERAL DIRECTOR <i>J. E. Myers Jr. Westminster, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR <b>JAN 19 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
VR A15 (4) 20M 1/65								



1  
FOR STATE  
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
00577		111567									
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE									
CARROLL COUNTY MARYLAND		MARYLAND CARROLL									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)									
RURAL WESTMINSTER		9 YRS.									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS									
OLD TANEY TOWN ROAD		RD #7 OLD TANEY TOWN ROAD 06-1									
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
PAUL BRUCE STARNER					JAN. 18	1966					
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.			
M		W			FEB 25 1889	76 yrs.	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
FARMER			FARM			CARROLL COUNTY			U.S.A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
JACOB D. STARNER		JESSIE BELLE DAYHOFF									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
NO.		220-34-5940		SON. DAVID STARNER		RT #1 WESTMINSTER, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosed (Acute) heart 260X DUE TO Arteriosclerosis, Cardiosclerosis several Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus (mild) DUE TO (c) Several											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>W. Glenn Speicher</i> CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
EXAMINER'S NAME (Type) <i>W. GLENN SPEICHER</i> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, City, Town, or County) <i>135 E. Chestnut Street, Westminster, MD.</i> 11-18-66 22. DATE SIGNED											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/21/66		23c. NAME OF CEMETERY OR CREMATORIUM RIDERS CEMETERY WESTMINSTER, MD.		23d. LOCATION (City, town or county) (State)					
24. FUNERAL DIRECTOR		ADDRESS James G. Saffell Jr. WESTMINSTER, MD.		25a. REC'D BY REGISTRAR JAN 20 1956		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
VR AISM (5) 5M 1/65											



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

**00578**

**00568**

1. PLACE OF DEATH a. COUNTY <b>CARROLL.</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>CARROLL</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER RUN.</b>		c. LENGTH OF STAY IN 1b <b>8 YRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER, MD. RD1 (SILVER RUN)</b>		d. STREET ADDRESS <b>RD1.</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WESTMINSTER, MD. RD1 (SILVER RUN).</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>DONALD.</b>		First <b>LEE.</b>	Middle <b>STONESIFER.</b>	Last <b>1</b>	DATE OF DEATH <b>1 20 1966.</b>	Month <b>1</b>	Day <b>20</b>	Year <b>1966.</b>		
4. SEX <b>MALE.</b>		6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/17/57</b>	9. AGE (In years last birthday) <b>8 yrs.</b>	IF UNDER 1 YEAR Months <b>06 - 1</b>	IF UNDER 24 HRS. Days <b>06 - 1</b>	Hours <b>06 - 1</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHILD.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>GETTYSBURG, PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>				
13. FATHER'S NAME <b>CARL DAVID STONESIFER.</b>		14. MOTHER'S MAIDEN NAME <b>CAROLE ECKARD.</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>PARENTS.</b>		Address <b>( ABOVE )</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRAIN STEM TUMOR.</b>										
237X Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO (TYPE UNDETERMINED.)										
INTERVAL BETWEEN ONSET AND DEATH <b>DEC 1964</b>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) <u>this hospital</u> attended the deceased from <u>12/2</u> , 19 <u>64</u> , to <u>1/20</u> , 19 <u>66</u> , that (I) <u>last saw the deceased alive on</u> <u>1/20 1966</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.		22b. DATE SIGNED <b>1/20/66.</b>								
22a. SIGNATURE <b>John A. Grant.</b>		M.D. ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						
22c. PHYSICIAN'S NAME (Type) <b>JOHN A. GRANT.</b>		22d. ADDRESS <b>22 W. CHESTNUT ST. HANOVER, Pa.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/22/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>St. Marys Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Silver Run, Carroll Co. Md.</b>				
24. FUNERAL DIRECTOR <b>Richard A Little</b>		ADDRESS <b>Littlestown, Pa.</b>		25a. REC'D BY REGISTRAR <b>JAN 24 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Judge</b>				
VR A15 (4) 20M 1/65				DATE						



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00579

## CERTIFICATE OF DEATH

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aromatic rings and anti-clustering algorithm  
for the substances mentioned

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00580

00570

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

a. COUNTY

CARROLL

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

MIDDLEBURG

c. LENGTH OF STAY IN lb

APPROXIMATELY  
3 MONTHS

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

BROOKFIELD MANOR NURSING HOME

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

NANCY JANE TESTERMAN

4. DATE  
OF  
DEATH

JANUARY 28,

19 66

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

8. DATE OF BIRTH

JUNE 1, 1867

9. AGE (In years  
last birthday)

98 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

OWN HOME

11. BIRTHPLACE (County &amp; State, or foreign country)

ASH COUNTY, N. C.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

JUNIOR MOCK

14. MOTHER'S MAIDEN NAME

KATHERINE MOCK

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give war or dates of service)

NO

NONE

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

MRS. CORDIE TESTERMAN, STERLING, VA.

INTERVAL BETWEEN  
ONSET AND DEATH

years

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Generalized Atherosclerosis

4500

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last. } (b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

Left Lower Lobe pneumonia

19. WAS AUTOPSY  
PERFORMED?YES  NO 

MEDICAL CERTIFICATION

20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

19

p.m.

20d. INJURY OCCURRED

Whila Not Whila  
at work  at work 20a. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 5/10/59, 19....., to 1/28/66, 19....., that (I) last  
saw the deceased alive on 1/28/66, 19....., and that death occurred 8:30 AM, from the causes and on the date stated above.

22a. SIGNATURE

J. H. CARICOFE

M.D.

ATTENDING  
PHYS.MED.  
DIRECTORSTAFF  
PHYS.DATE  
SIGNED  
1/28/6622c. PHYSICIAN'S  
NAME (Type)

J. H. CARICOFE

22d. ADDRESS

UNION BRIDGE, MARYLAND.

23a. BURIAL, CREMATION, REMOVAL (Specify)

REMOVAL BURIAL 1-31-66

23c. NAME OF CEMETERY OR CREMATORI

STERLING CEMETERY,

23d. LOCATION (City, town or county)

(State)

STERLING, VIRGINIA

24 FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

J. Berkley Green, Herndon, Va.

25a. REC'D BY REGISTRAR

FEB 7 1966

1966

25b. REGISTRAR'S SIGNATURE

Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1660

HANGING FENCE

8300

US MAIL

1001 EXHIBITION

1001 ROCK

THE LEADERSHIP POSITION

DOOR

-7-

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

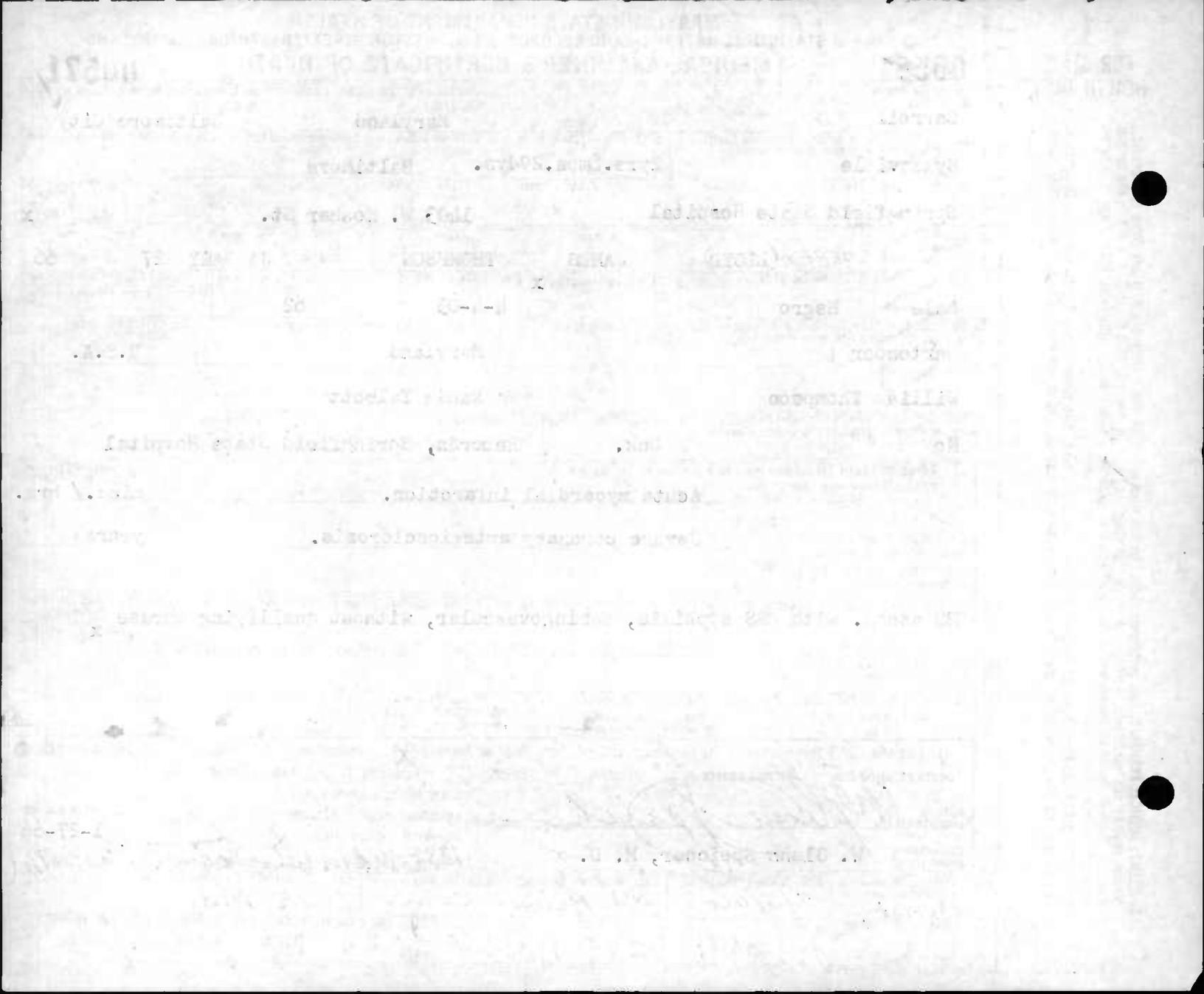
00581

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

110571

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>2 yrs. 8 mos. 29 days.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>		e. STREET ADDRESS <b>1403 W. Mosher St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>LURPEY (LLOYD)</b>		First <b>JAMES</b>	Middle <b>THOMPSON</b>
4. DATE OF DEATH <b>JANUARY 27 1966</b>		Last <b>THOMPSON</b>	Month <b>JANUARY</b> Day <b>27</b> Year <b>1966</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>4-4-03</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bartender</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Thompson</b>		14. MOTHER'S MAIDEN NAME <b>Nanie Talbott</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>	
17. INFORMANT <b>Records, Springfield State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction.</b>		INTERVAL BETWEEN ONSET AND DEATH mins./hrs.	
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4201</b>		DUE TO (b) <b>Severe coronary arteriosclerosis.</b> years	
		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <b>CBS assoc. with CNS syphilis, meningo-vascular, without qualifying phrase</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and In my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address: <b>1355 H Street NW, Washington, DC 20004</b>			
22. DATE SIGNED <b>1-27-66</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/5/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Auburn cem.</b>
24. FUNERAL DIRECTOR <b>W.C. Marsh 9288 Nolde</b>		ADDRESS <b>100 W. Mosher St. 9288 Nolde</b>	25a. REC'D BY REGISTRAR DATE <b>FEB 4 1966</b>
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician, director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

100582 100572

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>			c. LENGTH OF STAY IN 1b <b>32 yrs. 9 dys.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>JOEL</b>		First <b>K.</b>	Middle <b>TICE</b>	Last <b>January 18</b>	Month Year <b>1966</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-24-89</b>	9. AGE (In years last birthday) <b>76 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> 11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm hand</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>David M. Tice</b>			14. MOTHER'S MAIDEN NAME <b>Margaret O'Keefe</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Records, Springfield State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> 6000 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic pyelonephritis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <b>Schizophrenic reaction, other and unspecified</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH days years					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> p.m. at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1-9-34</b> , 19, to <b>1-18-66</b> , 19, that (I) (we) last saw the deceased alive on <b>1-18-66</b> , 19, and that death occurred at <b>1:15 A.M.</b> M, from the causes and on the date stated above.					
22a. SIGNATURE <i>Octavio A. Ruiz</i>		22b. DATE SIGNED <b>1-18-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Octavio A. Ruiz, M.D.</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland 21784</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL JAN - 20</b>		23b. DATE THEREOF <b>JAN - 20</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>RIVERVIEW</b>	
24. FUNERAL DIRECTOR <b>Adonal Bittner</b>		ADDRESS <b>Williamsport Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 20 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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prophase

pro P. over 50

metaphase II

last cell with bivalents

anaphase

cent.

prophase I

bival. etc.

metaphase I

anaphase I

last cell with bivalents, unpaired

unpaired

245

clump

metaphase

metaphase I, clump II

metaphase

metaphase II, clump II

metaphase II, bivalents

unpaired, clump

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00583

CERTIFICATE OF DEATH

00573

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Virginia</b>		b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>8 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Norfolk</b>		d. STREET ADDRESS <b>82-3</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH <b>Jan 23 1966</b>		Month Day Year				
3. NAME OF DECEASED (Type or print) <b>George Edward Turner</b>		First <b>George</b>	Middle <b>Edward</b>	Last <b>Turner</b>	Month <b>Jan</b>	Day <b>23</b>	Year <b>1966</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-25-1908</b>	9. AGE (In years last birthday) <b>57 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stevedore</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SHIPPING</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Robert Prince Turner</b>		14. MOTHER'S MAIDEN NAME <b>Sally Bryant</b>		Address						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Springfield State Hospital Records</b>		INTERVAL BETWEEN ONSET AND DEATH days				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Confulent Bronchopneumonia.</b>		OUE TO (b) <b>Heart failure due to Coronary arteriosclerosis</b>				weeks				
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. <b>4201</b>		(c) <b>and massive destruction with fibrosis of left ventricle wall.</b>				years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CBS assoc. with Alcoholic Intoxication with psychotic reaction.</b>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) <b>White at work</b>		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Springfield State Hospital</b>	20f. (City or town) <b>Sykesville</b>	(County) <b>Maryland</b>	(State) <b>MD</b>
21. I certify that (I) (this hospital) attended the deceased from <b>11-16-55</b> , 19 <b>19</b> , to <b>1-23-66</b> , 19 <b>19</b> , that (I) (we) last saw the deceased alive on <b>1-23-66</b> 19 <b>19</b> , and that death occurred at <b>3:15 P.M.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Samuel P. Wise, M.D.</b>		22b. DATE SIGNED <b>1-23-66</b>		22d. ADDRESS <b>Springfield State Hospital</b>				
22c. PHYSICIAN'S NAME (Type)		M.O. ATTENDING PHYS. <b>Samuel P. Wise, M.D.</b>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		23d. LOCATION (City, town or county) <b>Sykesville, Maryland</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>1-25-66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Family</b>		23d. LOCATION (City, town or county) <b>Charles J. Judge</b>				
24. FUNERAL DIRECTOR <b>Arthur W. Haight</b>		ADDRESS <b>Sykesville, Maryland</b>		25a. REC'D BY REGISTRAR <b>Charles J. Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Judge</b>				
VR A15 (4) 20M 1/65		DATE <b>JAN 26 1966</b>		25c. DATE <b>JAN 26 1966</b>						

Initial identification

Stephanus

Initial contact made

on

Initial identification completed

Initial contact made on 1st of June 1968

Initial identification completed on 1st of June 1968

X Initial identification completed on 1st of June 1968

Initial

Initial contact

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)											
a. COUNTY <b>Carr. all</b>				a. STATE <b>MARYLAND</b>											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>4 Days</b>											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield St. Hospital</b>				e. IS RESIDENCE DN A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>Sarah Elizabeth Wade</b>				First	Middle	Last	4. DATE OF DEATH <b>January 8 1966</b>	Month	Day	Year					
5. SEX <b>Female</b>				6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-10-93</b>	9. AGE (In years last birthday) <b>72 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS DR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William Moore</b>				14. MOTHER'S MAIDEN NAME <b>Annie Dorsey</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Springfield St. Hosp. Records</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH weeks			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b>															
4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic and rheumatic heart disease.</b>												years			
DUE TO (c) <b>Bronchopneumonia.</b>												days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>I-8</b> , 1966 to <b>I-8</b> , 1966, that (I) (we) last saw the deceased alive on <b>I-8</b> , 1966, and that death occurred at <b>I-8</b> , 1966, from the causes and on the date stated above.												22b. DATE SIGNED <b>I-8-66</b>			
22a. SIGNATURE <b>Frances Reid Nabors</b>				M.D. ATTENDING PHYS. <input type="checkbox"/>				MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>							
22c. PHYSICIAN'S NAME (Type) <b>Frances Reid Nabors</b>				22d. ADDRESS <b>Sykesville, Maryland</b>											
23a. BURIAL, CREMATION, REMDVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>1/12/66</b>				23c. NAME OF CEMETERY OR CREMATORIUM <b>Mt Auburn Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Baltimore Md</b>			
24. FUNERAL DIRECTOR <b>Adolphus Halstead</b>				ADDRESS <b>1206 W North Ave</b>								25a. REC'D BY REGISTRAR <b>JAN 14 1966</b>			
												25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

00585 00575

1. PLACE OF DEATH a. COUNTY  Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md. b. COUNTY Carroll					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN 1b 6 Months					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Jordan Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Etta E. Wagaman		4. DATE OF DEATH Jan. 11, 1966	Month Day Year				
5. SEX Female White		6. COLOR OR RACE WIDOWED <input checked="" type="checkbox"/>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/11/1877	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Cascade Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Nichols		14. MOTHER'S MAIDEN NAME Elizabeth Royer					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT S. Alan Wagaman,		Address Westminster Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Viral pneumonia and</i> <i>gastroenteritis</i> DUE TO <i>492X</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1/3/65</i> , 19 <i>66</i> , to <i>1/14</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>1/14</i> , 19 <i>66</i> , and that death occurred at <i>P.</i> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>Julius Chepko</i>							
22c. PHYSICIAN'S NAME (Type) <i>Julius Chepko</i>		22b. DATE SIGNED <i>1/14/66</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/17/66		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Bethel		23d. LOCATION (City, town or county) (State) County Lantz #1, Frederick Md.	
24. FUNERAL DIRECTOR <i>Walter J. Grove, Waynesboro Pa</i>		25a. REC'D BY REGISTRAR DATE JAN 17 1966					
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

Two returning birds  
arrived

Maintained records

After Copey  
at 9:00 AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00586

CERTIFICATE OF DEATH

00576

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>34yr. 6mo. 26dys.</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>ROSE</b>	Middle <b>H.</b>	Last <b>WELCH</b>			
4. DATE OF DEATH	Month <b>January</b>	Day <b>5</b>	Year <b>1966</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. OATE OF BIRTH <b>WIOOWEO</b> <input type="checkbox"/> DIVORCEO <input type="checkbox"/> <b>4-12-81</b>			
9. AGE (in years last birthday) <b>84 yrs.</b>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer (Weaver)</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Woolen Mill</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	13. FATHER'S NAME <b>Unknown</b>					
14. MOTHER'S MAIDEN NAME <b>Jacob Wm. Welch</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) <b>No</b>				
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Records, Springfield State Hospital</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>years</b> 4200 OUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> years OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Schizophrenia, paranoid type</b>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Springfield State Hospital</b>	20f. (City or town) <b>Springfield</b>	(County) <b>Montgomery</b>	(State) <b>M.D.</b>
21. I certify that (I) (this hospital) attended the deceased from <b>6-9-31</b> , 19 <b>14:15</b> , to <b>1-5-66</b> , 19 <b>14:15</b> , that (I) (we) last saw the deceased alive on <b>1-5-66</b> , 19, and that death occurred at <b>M</b> , from the causes and on the date stated above.						
22a. SIGNATURE <b>Sherill C. Cheeks</b>		22b. DATE SIGNED <b>1/5/66</b>				
22c. PHYSICIAN'S NAME (Type) <b>Sherill C. Cheeks, M.D.</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1/7/1966</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Good SHEPHERD</b>		23d. LOCATION (City, town or county) (State) <b>ELLIOTT CITY, MD.</b>
24. FUNERAL DIRECTOR <b>Easton Funeral Home - Catonsville</b>				25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>
				DATE <b>JAN 13 1966</b>		

as200

as200

Re Vermont Soil

million acre-feet

million acre-feet

1000  
800  
600  
400  
200  
0

water  
in  
soil

water > soil

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <b>Carroll</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE <b>MARYLAND</b>				b. COUNTY <b>Anne Arundel</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>36yr. 7mo.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>13 Tucker St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <b>Charles</b>	Middle <b>E</b>	Last <b>White</b>		4. DATE OF DEATH <b>Jan 22 1966</b>	Month <b>Jan</b>	Day <b>22</b>	Year <b>1966</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-5-1900</b>		9. AGE (in years last birthday) <b>66</b>	10. IF UNDER 1 YEAR Months <b>6</b>	11. IF UNDER 24 HRS. Days <b>6</b>	12. HOURS Hours <b>0</b>	13. MIN. Min. <b>0</b>			
14a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				14b. KIND OF BUSINESS OR INDUSTRY <b>—</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles White</b>		14. MOTHER'S MAIDEN NAME <b>Rose Morgan</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>	17. INFORMANT <b>Springfield Hospital Records</b>	Address <b>Sykesville Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio Vascular Disease</b> Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis Advanced</b> OUE TO (c) <b>—</b> OUE TO												INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Schizophrenic Reaction, Catatonic type</b>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>—</b>		(County) <b>—</b>	(State) <b>—</b>		
21. I certify that (I) (this hospital) attended the deceased from <b>633-29</b> , 19, to <b>1-22-66</b> 19, that (I) (we) last saw the deceased alive on <b>1-22-66</b> 19, and that death occurred <b>at 3:30 P.M.</b> from the causes and on the date stated above.												22a. SIGNATURE <i>Dr. Antonius Glahn</i>	22b. DATE SIGNED <b>1-22-66</b>
22c. PHYSICIAN'S NAME (Type) <b>Antonius Glahn, M.D.</b>				22d. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>1-25-66</b>				23c. NAME OF CEMETERY OR CREMATORIAL <b>CEDAR Bluff</b>				23d. LOCATION (City, town or county) <b>Annapolis MD.</b>	
24. FUNERAL DIRECTOR <b>John M. Kay Jr. Sons Annapolis MD.</b>				25a. REC'D BY REGISTRAR <b>MAN 25 1966</b>				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
VR A15 (4) 20M 1/65													

AM 182-2  
Hypobaptis

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182-2

GDBRBPNT

AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Carroll</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>				b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>8mos. 23dys.</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>1703 Ashburton St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)			First <b>GOALS</b>	Middle <b>SAMUEL</b>	Last <b>WILSON</b>	4. DATE OF DEATH <b>JANUARY 14 1966</b>	Month <b>JANUARY</b>	Day <b>14</b>	Year <b>1966</b>		
5. SEX <b>Male</b>			6. COLOR OR RACE <b>Negro</b>	7. MARRIED WIDOWED <b>Sep</b>	NEVER MARRIED DIVORCED <b>Divorced</b>	8. DATE OF BIRTH <b>7-20-1904</b>	9. AGE (In years last birthday) <b>61 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b>	Days <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Embalmer</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Samuel Wilson</b>			14. MOTHER'S MAIDEN NAME <b>Rachel Hutton</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>217-03-3889A</b>			17. INFORMANT <b>Records, Springfield State Hospital</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive bleeding from varices and hepatic coma.</b> INTERVAL BETWEEN ONSET AND DEATH <b>days</b> 5811 OUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Larnnec's cirrhosis of the liver.</b> years (c) DUE TO DUE TD (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>4-21-65</b> , 19 <b>to 1-14-66</b> , 19, that (I) (we) last saw the deceased alive on <b>1-14-66</b> , 19, and that death occurred at <b>3:55 PM</b> , from the causes and on the date stated above.			22b. DATE SIGNED <b>1-14-66</b>								
22a. SIGNATURE <i>Octavio A Ruiz</i>			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <b>1-14-66</b>								
22c. PHYSICIAN'S NAME (Type) <b>Octavio A. Ruiz, M. D.</b>			22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>1-18-66</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>MOUNT CALVARY</b>			23d. LOCATION (City, town or county) (State) <b>Arundel Co Md.</b>		
24. FUNERAL DIRECTOR <b>I.L Brown + Son</b>			ADDRESS <b>Balto. Md. 21234, MONTGOMERY</b>			25a. REC'D BY REGISTRAR <b>JAN 19 1966</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		
									DATE		

2320

hazard

disorder

exposed

intensity

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critical to the system

to

100%

cycle time

and yet

continued

sodium load

stable enough

so that each individual event - 100% TIS

can now be seen as a single unit of time.

that is to say it is

2

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
00589						00579							
1. PLACE OF DEATH a. COUNTY		CERTIFICATE OF DEATH											
<i>Carroll</i>		MARYLAND											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)									
<i>New Windsor Rd #1 all his life</i>				a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)											
		<i>New Windsor Rd #106-1</i>											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS											
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year					
<i>HARRY EDWIN WILSON</i>					<i>January 27 1966</i>								
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS						
<i>Male</i>		<i>Colored</i>	<i>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></i>	<i>May 29 1907</i>	<i>58 yrs.</i>	<i>Montue</i>	<i>Days</i>	<i>Hours</i>	<i>Min.</i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
<i>Kitchen Helper</i>		<i>College dining room</i>		<i>New Windsor Rd. Md. U.S.A.</i>		<i>Address</i>							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME											
<i>John Wilson</i>		<i>Mary Jane Johnson</i>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH					
		<i>213-16-0957</i>		<i>Mrs Walter Smo. Jr. New Windsor Rd #1</i>		<i>Coronary occlusion</i>		<i>10 minutes</i>					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO											
<i>4201</i>				(b)									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO											
		(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)													
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
<i>19</i>													
21. I certify that (I) (this hospital) attended the deceased from <i>9/7 1965</i> , to <i>1/27 1966</i> , that (I) (we) last saw the deceased alive on <i>1/27 1966</i> , and that death occurred at <i>1/30 M</i> , from the causes and on the date stated above.													
22a. SIGNATURE <i>Julius Chepko</i>													
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>1/26/66</i>					
<i>Julius Chepko</i>													
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>1/30/66</i>		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county) (State)							
<i>Burial</i>				<i>Westminster Cemetery New Windsor Rd #1 Md.</i>									
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR <i>FEB 1 1966</i>		25b. REGISTRAR'S SIGNATURE							
<i>J. E. Myers Jr.; Westminster, Md.</i>													
DATE													

25210

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25210  
25210

Aug 15 2010

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
00590			00580											
1. PLACE OF DEATH a. COUNTY		Carroll			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Rural Taneytown			e. STATE		b. COUNTY Carroll						
c. LENGTH OF STAY IN lb						Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						Rural Taneytown		06-1						
RFD #2						d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH		Month	Day	Year				
Norman			Wilson		Wood	January		26	19	66				
S. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	IF UNDER 24 HRS.					
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	June 28, 1921		44 yrs.		Months	Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?					
None			None			Rockingham Co., Virginia			U.S.A.					
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			Address								
Ellis Leonard Wood			Mary Ann Shifflett											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war record of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]					
No			None			Ellis L. Wood			RFD #2 Taneytown, Md.					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Coronary Occlusion						INTERVAL BETWEEN ONSET AND DEATH Severed by					
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) HyperTension & Cardio-Vascular Dis.						5 yrs					
{			(c) Generalized Arteriosclerosis						5 yrs					
DUE TO														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)														
Obesity														
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Hour e.m. p.m.			Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from June 7, 1965, to Jan 22, 1966, that (I) (we) last saw the deceased alive on Jan 22, 1966, and that death occurred at 11:20 P.M., from the causes and on the date stated above.														
22e. SIGNATURE E. Ambler Thompson, M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 1/28/66								
22c. PHYSICIAN'S NAME (Type) E. Ambler Thompson, M.D.			22d. ADDRESS 49 Frederick Street, Taneytown, Md.											
23e. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 1/29/66			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Reformed Cemetery			23d. LOCATION (City, town or county) Taneytown					
24 FUNERAL DIRECTOR'S SIGNATURE C.O. Fuss & Son									23b. REGISTRAR'S SIGNATURE FEB 1 1966					

